

CHAPTER 59E-7 INPATIENT DATA COLLECTION

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59E-7.012 Inpatient Data Reporting Instructions.

All hospitals reporting their inpatient discharge data shall submit a zipped inpatient discharge data file by Internet according to the specifications in subsections (1) through (3).

(1) The Internet address for the receipt of inpatient data is <https://apps.ahca.myflorida.com/patientdata/>.

(2) **Data reported for visits occurring before first quarter 2018** to the Internet address shall be electronically transmitted with the zipped inpatient data in a XML file using the Inpatient Data XML PD10-3 Schema available at: <http://ahca.myflorida.com/xmlschemas/PD10-3.xsd>. The Inpatient Data XML PD10-3 Schema (effective 10/01/2015) is incorporated by reference at <http://www.flrules.org/Gateway/reference.asp?No=Ref-05412>.

(3) **Beginning with first quarter 2018 data reporting period as defined in** 59E-7.023(1)(c), Inpatient patient Data must be submitted using the Inpatient Data XML PD10-4 Schema available at: <http://ahca.myflorida.com/xmlschemas/PD10-4.xsd>. The Inpatient Data XML **PD10-4 Schema (effective 01/01/2018)** is incorporated by reference at <http://www.flrules.org/Gateway/reference.asp?No=Ref-08830>.

(4) The data in the XML file shall contain the data elements, codes and standards required in Rules 59E-7.027, 59E-7.028 and 59E-7.030, F.A.C.

Rulemaking Authority 408.061(1)(e,), 408.15(8)) FS. Law Implemented 408.061, 408.062, 408.063 FS. History—New 12-15-96, Amended 1-4-00, 7-11-01, 7-12-05, 5-22-07, 1-1-10, 10-1-15, 01-1-18.

59E-7.021 Definitions.

(1) “Acute Care” means inpatient general routine 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.

(2) “Comprehensive Rehabilitation” means services provided in a Specialty Rehabilitation Hospital licensed under Chapter 395, F.S., or services provided in a hospital rehabilitation distinct part unit.

(3) “Distinct Part Unit” means a unique unit or level of care at a hospital requiring the issuance of a separate claim to a payer.

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

(5) “Executive Officer” means a reporting facility’s chief executive officer, chief financial officer, chief operating officer,

president, or any vice president of the hospital in charge of a principal business unit, division or function (administration or finance).

(6) “Inpatient” means a patient who has an admission order given by a licensed physician or other individual who has been granted admitting privileges by the hospital. Observation patients are excluded.

(7) “Newborn” means a baby born within the hospital or the initial admission of an infant to any hospital within 24 hours of birth. Excludes babies born in a different hospital and transferred to the reporting hospital.

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

(9) “NUBC” means National Uniform Billing Committee. A national body that defines the data elements that are reported on the Uniform Bill UB-04 and annually publishes an Official UB-04 Data Specifications Manual.

(10) ISO 3166 – The International Standard for Organization is a standardized list of country names and codes first published in 1974 and updated 2008. ISO 3166 is available at: http://www.iso.org/iso/english_country_names_and_code_elements.

Rulemaking Authority 408.061(1)(e), 408.15(8) FS. Law Implemented 408.061 FS. History—New 1-1-10, Amended 12-5-10, Formerly 59E-7.011, Amended 10-1-15, 01-1-18.

59E-7.022 Inpatient Data Reporting and Audit Procedures.

(1) Hospitals licensed under Chapter 395, F.S., except state-operated hospitals, in operation for all or any of the reporting periods described in subsection 59E-7.023(1), F.A.C., below, shall submit hospital inpatient discharge data to the Agency according to the provisions in Rules 59E-7.012 and 59E-7.021 through 59E-7.030, F.A.C.

(2) Each hospital shall submit a separate report for each location per Section 408.061(3), F.S.

(3) All acute, intensive care, long term acute care, short term and long term psychiatric, substance abuse and comprehensive rehabilitation live discharges and deaths, including newborn live discharges and deaths, shall be reported. Submit one record per inpatient discharge, to include all newborn admissions, transfers and deaths. Patients receiving rehabilitation services while in the acute care setting (not discharged or transferred to a distinct part unit) are included in the inpatient reporting for service type 1. Report all rehabilitation services provided in either a rehabilitation hospital or in a non-acute distinct part unit in the inpatient reporting for service type 2.

(4) Upon notification by the Agency staff, all hospitals shall provide access to all required information from the medical records and billing documents underlying and documenting the hospital inpatient discharge reports submitted, as well as other inpatient related documentation deemed necessary to conduct complete inpatient data audits of hospital data, subject to the limitations as set forth in Section 408.061(1)(d), F.S. No inpatient discharge records that support inpatient discharge data are exempt from disclosure to the Agency for audit purposes.

Rulemaking Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063, 408.05, 408.08(1) FS. History—New 1-1-10, Formerly 59E-7.012, Amended 01-1-18.

59E-7.023 Schedule for Submission of Inpatient Data.

(1) All hospitals reporting their inpatient discharge data shall report according to the following schedule.

(a) Each report submitted for the 1st quarter covering inpatient discharges occurring between January 1 and March 31, inclusive, of each year, shall be submitted no later than June 1 of the calendar year during which the discharge occurred. This is considered to be the first quarter, regardless of the hospital’s fiscal year. First quarter reports must be certified by August 31 of the same calendar year.

(b) Each report submitted for the 2nd quarter covering inpatient discharges occurring between April 1 and June 30, inclusive, of each year, shall be submitted no later than September 1 of the calendar year during which the discharge occurred. This is considered to be the second quarter, regardless of the hospital’s fiscal year. Second quarter reports must be certified by November 30 of the same calendar year.

(c) Each report submitted for the 3rd quarter covering inpatient discharges occurring between July 1 and September 30, inclusive, of each year, shall be submitted no later than December 1 of the calendar year during which the discharge occurred. This is considered to be the third quarter, regardless of the hospital’s fiscal year. Third quarter reports must be certified by February 28 of the following calendar year.

(d) Each report submitted for the 4th quarter covering inpatient discharges occurring between October 1 and December 31, inclusive, of each year, shall be submitted no later than March 1 of the calendar year following the year in which the discharge

occurred. This is considered to be the fourth quarter, regardless of the hospital's fiscal year. Fourth quarter reports must be certified by May 31 of the next calendar year.

(2) Failure to file the report on or before the certification due date as specified in paragraphs 59E-7.023(1)(a)-(d), F.A.C., and failure to correct a report which has been filed but contains errors or deficiencies by the certification deadline is punishable by fine pursuant to Rule 59E-7.026, F.A.C. The Agency shall send notification of errors or deficiencies by electronic mail, or fax. Rejected reports must be corrected, resubmitted and certified by the certification due date.

Rulemaking Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063, 408.05, 408.07(2), 408.15(11) FS. History--New 1-1-10, Formerly 59E-7.012, Amended 01-1-18.

59E-7.025 Certification, Audits and Resubmission Procedures.

(1) Data submissions for all hospitals centers must be in compliance with Rules 59E-7.012 and 59E-7.021 through 59E-7.030, F.A.C.; The **executive officer, administrator, or authorized designee** shall certify the data quarterly as accurate, complete and verifiable by completing and signing IP Certification Form for Inpatient Patient Data, AHCA Form 4200-002, July 2017, incorporated by reference and available at <http://www.flrules.org/Gateway/reference.asp?No=Ref-08831>. The completed certification form attests the inpatient data report has been examined and, to the best of their knowledge and belief, the information contained in this report is true, accurate, and complete, and has been prepared from the books and records of this facility, except as noted. The completed certification form must be either mailed to the Agency for Health Care Administration, 2727 Mahan Drive, MS #16, Tallahassee, Florida 32308. Attention: Florida Center for Health Information and Transparency; or by facsimile to the Agency's office; or a scanned certification submitted by electronic mail by the certification due date. The Agency will send a certification package to the reporting entity once their data file is complete for certification. Upon receipt of a facility's signed certification form, the facility is considered "certified" for the reporting quarter.

(2) Hospitals whose data is not certified within five (5) calendar months following the last day of the reporting quarter shall be subject to penalties pursuant to Rule 59E-7.026, F.A.C. A facility will not be penalized for delays caused by the Agency which is documented by the reporting facility to include on-line reporting system downtime or delays in receipt of reports from the Agency.

(3) Changes or corrections to certified hospital data may be accepted from hospitals for a period of **twelve (12)** months following the initial submission due date. The Agency may grant approval if it determines that resubmission will significantly impact data quality. The **executive officer, administrator, or authorized designee** must provide a signed written request to the Agency to request resubmission. The written request must specify the reason for the corrections or changes, explain the cause contributing to the inaccurate reporting, describe a corrective action plan to prevent future errors, the total number of records affected by quarters and years, the data type and the date that the replacement file will be submitted to the Agency. Any changes to a hospital's data after this twelve month period shall be subject to penalties pursuant to Rule 59E-7.026, F.A.C. Resubmission of previously certified data must be certified within thirty (30) days following receipt of the data file from the facility.

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

Rulemaking Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063, 408.15(11), 408.08(1)(2) FS. History--New 1-1-10, Formerly 59E-7.012, Amended 01-1-18.

59E-7.026 Penalties for Hospital Inpatient Discharge Data Reporting Discrepancies.

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

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

(3) Notifications will be sent to reporting facilities who do not submit their data file by the initial due date as specified in Rule 59E-7.023, F.A.C.

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

(5) Any hospital which is delinquent for a certification deadline as specified in Rule 59E-7.023, F.A.C., shall be subject to a fine of \$100 per day of violation for the first violation, \$350 per day of violation for the second violation, and \$1,000 per day of violation for the third and all subsequent violations. **Following four consecutive non-delinquent quarters, the fine violation matrix will reset to the first violation rate.** Violations will be considered those activities which necessitate the issuance of an administrative complaint by the Agency unless the administrative complaint is withdrawn or final order dismissing the administrative complaint is entered. Any hospital which files false information to the Agency shall be subject to a fine not exceeding \$1000 per day per violation, in addition to any other fine imposed hereunder.

Rulemaking Authority 408.061(1)(e), 408.15(8), 408.813 FS. Law Implemented 408.08(2),(3),(5), 408.813 FS. History—New 1-10-10, Formerly 59E-7.013, Amended 01-1-18.

59E-7.027 Header Record.

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

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

(2) Report Year. Enter the year of the data in the format YYYY where YYYY represents the year in four (4) digits. A required field.

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

(4) **Data Type. Enter PD10**-4 for Inpatient Data. A required field.

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

(6) Processing Date. Enter the date that the data file was created in the format YYYY-MM-DD where MM represents numbered months of the year from 01 to 12, DD represents numbered days of the month from 01 to 31, and YYYY represents the year in four (4) digits. A required field.

(7) AHCA Facility Number. Enter the identification number of the facility as assigned by the Agency for reporting purposes. A valid identification number must contain at least eight (8) digits and no more than ten (10) digits. A required field.

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

(9) Organization Name. Enter the name of the hospital from which the patient was discharged, and which is responsible for reporting the data. All questions regarding data accuracy and integrity will be referred to this entity. Up to a forty-character field. A required field.

(10) Contact Person Name. Enter the name of the contact person for the hospital. Submit name in the Last, First format. Up to a twenty-five-character field. A required field.

(11) Contact Phone Number. The area code, business telephone number, and if applicable, extension for the contact person. Enter the contact person's telephone number in the numeric format (AAA)XXXXXXXXXXXX where AAA is the area code, XXXXXXXX represents the seven (7) digit phone number and EEEE represents the extension. Zero fill if no extension. A required field.

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

(13) Contact Person Street or P. O. Box Address. Enter the street or post office box address of the contact person's mailing address. Up to a forty-character field. A required field.

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

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

(16) Mailing Address Zip Code. Enter the numeric zip code of the contact person's address in the format XXXXX-XXXX.

59E-7.028 Inpatient Data Elements, Codes and Standards.

All hospitals submitting data in compliance with Rules 59E-7.012 and 59E-7.021 through 59E-7.030, F.A.C., shall report the required data elements and data element codes listed below as stipulated by the Agency.

(1) AHCA Facility Number. Enter the identification number of the hospital as assigned by the Agency for reporting purposes. A valid identification number must contain at least eight (8) digits and no more than ten (10) digits. A required field.

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

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

(4) Patient Social Security Number. The social security number (SSN) of the patient. The SSN is a nine (9) digit number issued by the Social Security Administration used to facilitate retrieval of individual case records, track multiple patient discharges and for medical research. Reporting 77777777 is acceptable for those patients where efforts to obtain the SSN have been unsuccessful or the patient is under two (2) years of age and does not have a SSN or for patients who are non-U.S. citizens who have not been issued SSNs. If only the last four digits of a patients SSN are known, report 7777XXXX where XXXX represent the last known four digits of the patient SSN. **The last four digit SSN format must be used only when the full SSN is unknown and not as a substitute for all nine digit SSN's.** A required entry.

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

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

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

(c) E7 = Unknown.

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

(a) 1 – American Indian or Alaska 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.

(b) 2 – Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. This area includes, for example, Cambodia, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

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

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

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

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

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

(7) Patient Birth Date. The date of birth of the patient. A ten (10) character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 01 to 12, DD represents numbered days of the month from 01 to 31, and YYYY represents the year in four (4) digits. Unknown birthdates should use the default of 1880-01-01. A birth date after the discharge date is not permitted. A required entry.

(8) Patient Sex. The patient sex at the time of admission. A required entry. Must be a one (1) alpha character in upper case as follows:

(a) M – Male;
(b) F – Female; and,
(c) U – Unknown – Use where efforts to obtain the information have been unsuccessful or where the patient’s sex cannot be determined due to a medical condition.

(9) Patient Zip Code. The numeric five (5) digit United States Postal Service ZIP Code of the patient’s address. Use 00009 for foreign residences. Use 00007 for homeless patients. Use 00000 where efforts to obtain the information have been unsuccessful. A required entry.

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

(11) Type of Service Code. A code designating the type of discharges as either acute inpatient, long term care, short term and long term psychiatric, or comprehensive rehabilitation. A required entry. Must be a one digit code as follows:

- (a) 1 – Inpatient, as described in subsection 59E-7.021(6), F.A.C.; and,
- (b) 2 – Comprehensive Rehabilitation, as described in subsection 59E-7.021(2), F.A.C.

(12) Priority of Admission. The scheduling priority of the initial admission. A required entry. Must be a one (1) digit code as follows:

- (a) 1 – Emergency. The patient requires immediate medical intervention as a result of severe, life-threatening or potentially disabling conditions;
- (b) 2 – Urgent. The patient requires attention for the care and treatment of a physical or mental disorder;
- (c) 3 – Elective. The patient’s condition permits adequate time to schedule the services;
- (d) 4 – Newborn. A baby born within the facility or the initial admission of an extramural birth infant to an acute care facility within 24 hours of birth, as described in subsection 59E-7.021(7), F.A.C. Use of this code requires the use of a special Point of Origin for Admission code; and,
- (e) 5 – Trauma. A patient treated as a trauma patient with or without trauma activation at a State of Florida designated trauma center.

(13) Source or Point of Origin for Admission. Must be a one (1) character alpha code or two (2) digit numeric code indicating the direct source of patient origin for the admission or visit. Codes 10 or 13 are to be used only for newborn admissions. A required entry. Alpha characters must use upper case.

- (a) 01 – Non-health care facility point of origin. The patient was admitted to this facility. Includes a patient coming from home or workplace.
- (b) 02 – Clinic or Physician’s Office. The patient was admitted to this facility from a clinic or physician’s office.
- (c) 04 – Transfer from a hospital. The patient was admitted to this facility as a transfer from an acute care facility where the patient was an inpatient. Transfer must be from a different hospital. Excludes transfers from hospital inpatients in the same facility.
- (d) 05 – Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). The patient was admitted to this facility from a SNF or ICF where the patient was a resident.
- (e) 06 – Transfer from another health care facility. The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list.
- (f) 08 – Court/Law Enforcement. The patient was admitted upon the direction of a court of law, or upon the request of a law enforcement Agency representative. Includes transfers from incarceration facilities.
- (g) 09 – Information Not Available. The means by which the patient was admitted to this hospital is not known.
- (h) D – Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim. The patient was admitted to this facility as a transfer from hospital inpatient within this hospital resulting in a separate claim to the payer. For purposes of this code, “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.
- (i) E – Transfer from an Ambulatory Surgery Center.
- (j) F – Transfer from a hospice facility and under a hospice plan of care or enrolled in a hospice program.

Codes required for newborn admissions (Priority of Admission=4):

- (k) 10 – Born inside this hospital; and,
- (l) 13 – Born outside this hospital.

(14) Admission Date. The date the patient was admitted to the initial reporting facility. A ten (10) character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 01 to 12, DD represents numbered days of the month from 01 to 31, and YYYY represents the year in four (4) digits. Admission date must equal or precede the discharge date. A required entry.

(15) Inpatient Admission Time. The hour on a 24-hour clock during which the patient's initial inpatient admission to the hospital occurred. A required entry. Use 99 where efforts to obtain the information have been unsuccessful. Must be two digits as follows:

A.M. HOURS

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

P.M. HOURS

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

(16) Discharge Date. The date the patient was discharged from the reporting facility. A ten (10) character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 01 to 12, DD represents numbered days of the month from 01 to 31, and YYYY represents the year in four (4) digits. Discharge date must equal or follow the admission date, and discharge date must occur within the reporting period as shown on the header record. A required entry.

(17) Discharge Time. The hour on a 24-hour clock in which the patient was discharged from the discharging hospital. A required entry. Use 99 where efforts to obtain the information have been unsuccessful. Must be two digits as follows:

A.M. HOURS

- (a) 00 – 12:00 midnight to 12:59:59
- (b) 01 – 01:00 to 01:59:59
- (c) 02 – 02:00 to 02:59:59
- (d) 03 – 03:00 to 03:59:59
- (e) 04 – 04:00 to 04:59:59
- (f) 05 – 05:00 to 05:59:59
- (g) 06 – 06:00 to 06:59:59
- (h) 07 – 07:00 to 07:59:59

- (i) 08 – 08:00 to 08:59:59
- (j) 09 – 09:00 to 09:59:59
- (k) 10 – 10:00 to 10:59:59
- (l) 11 – 11:00 to 11:59:59

P.M. HOURS

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

(18) Patient Discharge Status. Patient disposition at discharge. A required entry. Must be a two (2) digit code as follows:

- (a) 01 – Discharged to home or self-care (routine discharge).
- (b) 02 – Discharged or transferred to a short-term general hospital for inpatient care.
- (c) 03 – Discharged or transferred to a skilled nursing facility with Medicare certification in anticipation of skilled care.
- (d) 04 – Discharged or transferred to an intermediate care facility.
- (e) 05 – Discharged or transferred to a designated cancer center or Children's Hospital.
- (f) 06 – Discharged or transferred to home under care of home health care organization service in anticipation of skilled care.
- (g) 07 – Left the hospital against medical advice (AMA) or discontinued care.
- (h) 20 – Expired.
- (i) 21 – Discharged or transferred to court/law enforcement.
- (j) 50 – Hospice-Home.
- (k) 51 – Hospice Medical Facility (Certified) providing hospice level of care.
- (l) 62 – Discharged or transferred to an Inpatient Rehabilitation Facility (IRF) including rehabilitation distinct part units of a hospital.
- (m) 63 – Discharged or transferred to a Medicare certified long term care hospital.
- (n) 64 – Discharged or transferred to a Nursing Facility certified under Medicaid but not certified under Medicare.
- (o) 65 – Discharged or transferred to a psychiatric hospital including psychiatric distinct part units of a hospital.
- (p) 66 – Discharged or transferred to a Critical Access hospital.
- (q) 70 – Discharged or transferred to another type of health care institution not defined elsewhere in this code list.

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

- (a) A – Medicare. Patients covered by Medicare where Centers for Medicare and Medicaid Services is the direct payer.
- (b) B – Medicare Managed Care. Patients covered by Medicare Advantage plans, Medicare HMO, Medicare PPO, Medicare Private Fee for Service or any other type of Medicare plan where Centers for Medicare & Medicaid Services is not the direct payer.
- (c) C – Medicaid. Patients covered by state administered Florida Medicaid where the payment is directly from the State of Florida Medicaid program.
- (d) D – Medicaid Managed Care. Patients covered by Medicaid funded capitated plans. This would include any program where the patient is enrolled in the Medicaid program but the payment is not directly from the state of Florida Medicaid program. This designation is to be used regardless of whether the hospital has a contract with that plan.
- (e) E – Commercial Health Insurance. Patients covered by any type of private coverage, including HMO, PPO, self-insured plans.

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

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

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

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

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

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

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

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

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

(20) Principal Diagnosis Code. 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. A diagnosis code cannot be used more than once as a principal or other diagnosis for each hospitalization reported. The code must be entered with a decimal point that is included in the valid code. A required entry. Alpha characters must be in upper case.

(21) Other Diagnosis Code (1), Other Diagnosis Code (2), Other Diagnosis Code (3), Other Diagnosis Code (4), Other Diagnosis Code (5), Other Diagnosis Code (6), Other Diagnosis Code (7), Other Diagnosis Code (8), Other Diagnosis Code (9), Other Diagnosis Code (10), Other Diagnosis Code (11), Other Diagnosis Code (12), Other Diagnosis Code (13), Other Diagnosis Code (14), Other Diagnosis Code (15), Other Diagnosis Code (16), Other Diagnosis Code (17), Other Diagnosis Code (18), Other Diagnosis Code (19), Other Diagnosis Code (20), Other Diagnosis Code (21), Other Diagnosis Code (22), Other Diagnosis Code (23), Other Diagnosis Code (24), Other Diagnosis Code (25), Other Diagnosis Code (26), Other Diagnosis Code (27), Other Diagnosis Code (28), Other Diagnosis Code (29), and Other Diagnosis Code (30). A code representing a condition that is related to the services provided during the hospitalization excluding external cause of morbidity codes. Report external cause of morbidity codes as described in subsection (61) below. No more than thirty (30) other diagnosis codes may be reported. Less than thirty (30) entries is permitted. If an Other Diagnosis Code is reported, a valid Principal Diagnosis code must be reported. Must contain a valid ICD-10-CM code for the reporting period. An Other Diagnosis Code cannot be used more than once as a principal or other diagnosis for each hospitalization reported. The code must be entered with use of a decimal point that is included in the valid code. Alpha characters must be in upper case.

(22) Present on Admission Indicator for Principal Diagnosis Code, Present on Admission for Other Diagnosis Code (1), Present on Admission Indicator for Other Diagnosis Code (2), Present on Admission Indicator for Other Diagnosis Code (3), Present on Admission Indicator for Other Diagnosis Code (4), Present on Admission Indicator for Other Diagnosis Code (5), Present on Admission Indicator for Other Diagnosis Code (6), Present on Admission Indicator for Other Diagnosis Code (7), Present on Admission Indicator for Other Diagnosis Code (8), Present on Admission Indicator for Other Diagnosis Code (9), Present on Admission Indicator for Other Diagnosis Code (10), Present on Admission Indicator for Other Diagnosis Code (11), Present on Admission Indicator for Other Diagnosis Code (12), Present on Admission Indicator for Other Diagnosis Code (13), Present on Admission Indicator for Other Diagnosis Code (14), Present on Admission Indicator for Other Diagnosis Code (15), Present on Admission Indicator for Other Diagnosis Code (16), Present on Admission Indicator for Other Diagnosis Code (17), Present on Admission Indicator for Other Diagnosis Code (18), Present on Admission Indicator for Other Diagnosis Code (19), Present on Admission Indicator for Other Diagnosis Code (20), Present on Admission Indicator for Other Diagnosis Code (21), Present on Admission Indicator for Other Diagnosis Code (22), Present on Admission Indicator for Other Diagnosis Code (23), Present on Admission Indicator for Other Diagnosis Code (24), Present on Admission Indicator for Other Diagnosis Code (25), Present on Admission Indicator for Other Diagnosis Code (26), Present on Admission Indicator for Other Diagnosis Code (27), Present on Admission Indicator for Other Diagnosis Code (28), Present on Admission Indicator for Other Diagnosis Code (29), Present on

Admission Indicator for Other Diagnosis Code (30), Present on Admission Indicator for External Cause of Morbidity Code (1), Present on Admission Indicator for External Cause of Morbidity Code (2), and Present on Admission Indicator for External Cause of Morbidity Code (3). A code differentiating whether the condition represented by the corresponding Principal Diagnosis Code (20), Other Diagnosis Code (21), (1) through (30), and External Cause of Morbidity Code (61), (1) through (3), was present on admission or whether the condition developed after admission as determined by the physician, medical record or nature of the condition. A required entry.

(a) Y – Yes. Present at the time that the order for inpatient admission occurs.

(b) N – No. Not present at the time that the order for inpatient admission occurs.

(c) U – Unknown. Documentation is insufficient to determine if condition is present on admission.

(d) W – Clinically Undetermined. Provider is unable to clinically determine whether condition was present on admission or not.

(e) 1 – Exempt. A condition that is included on the current Centers for Medicare & Medicaid Services ICD-CM “Exempt from Reporting” list.

(23) Principal Procedure Code. The code representing the procedure most related to the principal diagnosis. No entry is permitted consistent with the records of the reporting entity. Must contain a valid ICD-10-PCS procedure code for the reporting period. If a principal procedure date is reported, a valid principal procedure code must be reported. Alpha characters must be in upper case.

(24) Principal Procedure Date. The date when the principal procedure was performed. If a principal procedure is reported, a principal procedure date must be reported. No entry is permitted if no principal procedure is reported. A ten (10)-character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 01 to 12, DD represents numbered days of the month from 01 to 31, and YYYY represents the year in four (4) digits. The principal procedure date must be less than seven (7) days prior to the admission date and not later than the discharge date.

(25) Other Procedure Code (1), Other Procedure Code (2), Other Procedure Code (3), Other Procedure Code (4), Other Procedure Code (5), Other Procedure Code (6), Other Procedure Code (7), Other Procedure Code (8), Other Procedure Code (9), Other Procedure Code (10), Other Procedure Code (11), Other Procedure Code (12), Other Procedure Code (13), Other Procedure Code (14), Other Procedure Code (15), Other Procedure Code (16), Other Procedure Code (17), Other Procedure Code (18), Other Procedure Code (19), Other Procedure Code (20), Other Procedure Code (21), Other Procedure Code (22), Other Procedure Code (23), Other Procedure Code (24), Other Procedure Code (25), Other Procedure Code (26), Other Procedure Code (27), Other Procedure Code (28), Other Procedure Code (29) and Other Procedure Code (30). A code representing a procedure provided during the hospitalization. If a principal procedure is not reported, an Other Procedure Code must not be reported. No more than thirty (30) other procedure codes may be reported. Less than thirty (30) or no entry is permitted. Must be a valid ICD-10-PCS procedure code for the reporting period. Alpha characters must be in upper case.

(26) Other Procedure Code Date (1), Other Procedure Code Date (2), Other Procedure Code Date (3), Other Procedure Code Date (4), Other Procedure Code Date (5), Other Procedure Code Date (6), Other Procedure Code Date (7), Other Procedure Code Date (8), Other Procedure Code Date (9), Other Procedure Code Date (10), Other Procedure Code Date (11), Other Procedure Code Date (12), Other Procedure Code Date (13), Other Procedure Code Date (14), Other Procedure Code Date (15), Other Procedure Code Date (16), Other Procedure Code Date (17), Other Procedure Code Date (18), Other Procedure Code Date (19), Other Procedure Code Date (20), Other Procedure Code Date (21), Other Procedure Code Date (22), Other Procedure Code Date (23), Other Procedure Code Date (24), Other Procedure Code Date (25), Other Procedure Code Date (26), Other Procedure Code Date (27), Other Procedure Code Date (28), Other Procedure Code Date (29) and Other Procedure Code Date (30). The date when the procedure was performed. A required entry if a corresponding procedure code (26), (1) through (30) is reported. A ten (10) character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 01 to 12, DD represents numbered days of the month from 01 to 31, and YYYY represents the year in four (4) digits. The procedure date must be less than seven (7) days prior to the admission date and not later than the discharge date.

(27) Attending Practitioner Identification Number. The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor or advanced registered nurse practitioner who had primary responsibility for the patient’s medical care and treatment or who certified as to the medical necessity of the services rendered. For military physicians not licensed in Florida, use US999999999. An alpha-numeric field of up to eleven characters. A required entry. Alpha characters must be in upper case.

(28) Attending Practitioner National Provider Identification (NPI). A unique ten (10) character identification number assigned

to a provider. A required entry for providers in the US or its territories and providers not in the US or its territories upon mandated HIPAA NPI implementation date. For military physicians, medical residents, or individuals not required to obtain a NPI number, use 9999999999.

(29) Operating or Performing Practitioner Identification Number. The Florida license number of the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor or advanced registered nurse practitioner who had primary responsibility for the principal procedure performed. The operating or performing practitioner may be the attending practitioner. For military physicians not licensed in Florida, use US9999999999. No entry is permitted if no principal procedure is reported. Alpha characters must be in upper case.

(30) Operating or Performing Practitioner National Provider Identification (NPI). A unique ten (10) character identification number assigned to a provider who had primary responsibility for the Principal Procedure performed. A required identification number for providers in the U.S. or its territories and providers not in U.S. or its territories upon mandated HIPAA NPI implementation date. For military physicians, medical residents, or individuals not required to obtain a NPI number, use 9999999999. No entry is permitted if no principal procedure is reported.

(31) Other Operating or Performing Practitioner Identification Number. The Florida license number of a medical doctor, osteopathic physician, dentist, podiatrist, chiropractor or advanced registered nurse practitioner who assisted the operating or performing practitioner or performed a secondary procedure. The other operating or performing practitioner must not be reported as the operating or performing practitioner. The other operating or performing practitioner may be the attending practitioner. For military physicians not licensed in Florida, use US9999999999. No entry is permitted consistent with the records of the reporting entity.

(32) Other Operating or Performing Practitioner National Provider Identification (NPI). A unique ten (10) character identification number assigned to a provider who assisted the operating or performing practitioner or performed a secondary procedure. A required identification number for providers in the U.S. or its territories and providers not in U.S. or its territories upon mandated HIPAA NPI implementation date. For military physicians, medical residents, or individuals not required to obtain a NPI number, use 9999999999. No entry is permitted if no principal procedure is reported.

(33) Room and Board Charges. Routine service charges incurred for accommodations. Report charges for revenue codes 11X through 16X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no Room and Board Charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(34) Nursery Level I Charges. Accommodation charges for well-baby care services which include sub-ventilation care, intravenous feedings and gavage to neonates. Report charges for revenue code 170 and 171, or 179 if applicable, as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no Nursery Charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(35) Nursery Level II Charges. Accommodation charges for services which include provision of ventilator services. Report charges for revenue code 172, or 179 if applicable, as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no Level II Nursery Charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(36) Nursery Level III Charges. Accommodation charges for services which include continuous cardiopulmonary support services, complex pediatric surgery, neonatal cardiovascular surgery, pediatric neurology and neurosurgery, and pediatric cardiac catheterization. Report charges for revenue code 173, 174, or 179 if applicable, as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no Level III Nursery Charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(37) Intensive Care Charges. Routine service charges for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit. Exclude neonatal intensive care charges reported as a Level III Nursery Charge. Report charges for revenue code 20X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no intensive care charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(38) Coronary Care Charges. Routine service charges for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical unit. Report charges for revenue code 21X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are

no coronary care charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(39) Pharmacy Charges. Charges for medication. Report charges for revenue codes 25X and 63X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no pharmacy charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(40) Medical and Surgical Supply Charges. Charges for supply items required for patient care. Report charges for revenue codes 27X and 62X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no medical and surgical supply charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(41) Laboratory Charges. Charges for the performance of diagnostic and routine clinical laboratory tests and for diagnostic and routine tests in tissues and culture. Report charges for revenue codes 30X and 31X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no laboratory charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(42) Radiology or Other Imaging Charges. Charges for the performance of diagnostic and therapeutic radiology services including computed tomography, mammography, magnetic resonance imaging, nuclear medicine, and chemotherapy administration of radioactive substances. Report charges for revenue codes 32X through 35X, 40X and 61X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no radiology or other imaging charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(43) Cardiology Charges. Facility charges for cardiac procedures rendered such as, but not limited to, heart catheterization or coronary angiography. Report charges for revenue code 48X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no cardiology charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(44) Respiratory Services or Pulmonary Function Charges. Charges for administration of oxygen, other inhalation services, and tests that evaluate the patient's respiratory capacities. Report charges for revenue codes 41X and 46X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no respiratory service or pulmonary function charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(45) Operating Room Charges. Charges for the use of the operating room. Report charges for revenue code 36X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no operating room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(46) Anesthesia Charges. Charges for anesthesia services by the facility. Report charges for revenue code 37X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no anesthesia charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(47) Recovery Room Charges. Charges for the use of the recovery room. Report charges for revenue code 71X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no recovery room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(48) Labor Room Charges. Charges for labor and delivery room services. Report charges for revenue code 72X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no labor room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(49) Emergency Room Charges. Charges for medical examinations and emergency treatment. Report charges for revenue code 45X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no emergency room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

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

verified separately by the reporting entity. A required entry.

(51) Treatment or Observation Room Charges. Charges for use of a treatment room or for the room charge associated with observation services. Report charges for revenue code 76X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no treatment or observation room charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(52) Behavioral Health Charges. Charges for behavioral health treatment and services. Report charges for revenue codes 90X through 91X and 100X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(53) Oncology. Charges for treatment of tumors and related diseases. Excludes therapeutic radiology services reported in radiology and other imaging services in subsection (42). Report charges for revenue code 28X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no oncology charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(54) Physical Therapy Charges. Charges for physical therapy in revenue code 42X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(55) Occupational Therapy Charges. Charges for occupational therapy for revenue code 43X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(56) Speech Therapy or Language Pathology Charges. Charges for speech therapy or language pathology therapy for revenue code 44X as used in the UB-04. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(57) **Comp Rehab Room Charges. Charges for comprehensive rehabilitation room charges for revenue codes 0118, 0128, 0138, 0148, 0158 as used in the UB-04.** Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(58) Other Charges. Other facility charges not included in subsections (33) to (56) above. Include charges that are not reflected in any of the preceding specific revenue accounts in the UB-04. Do not include charges from revenue codes 96X, 97X, 98X, or 99X in the UB-04 for professional fees and personal convenience items. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Report zero (0) if there are no other charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(59) Total Gross Charges. The total of undiscounted charges for services rendered by the hospital. Include charges for services rendered by the hospital excluding professional fees. The sum of all charges reported above in subsections (33) through (57) must equal total charges, plus or minus thirteen (\$13.00) dollars. Report in dollars rounded to the nearest whole dollar, without dollar signs or commas, excluding cents. Zero (0) or negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(60) Infant Linkage Identifier. The social security number of the patient's birth mother where the patient is less than two (2) years of age. 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. Reporting 777777777 for the mother's SSN is acceptable for those patients where efforts to obtain the mother's SSN have been unsuccessful or the mother is known to be from a country other than the United States. Infants in the custody of the State of Florida or adoptions, use 333333333 if the birth mother's SSN is not available. 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. A required entry.

(61) Admitting Diagnosis. The diagnosis provided by the admitting physician at the time of admission which describes the patient's condition upon admission or purpose of admission. Must contain a valid ICD-10-CM code for the reporting period. The code must be entered with use of a decimal point that is included in the valid code. A required entry. Alpha characters must be in upper case.

(62) External Cause of Morbidity Code (1), External Cause of Morbidity Code (2) and External Cause of Morbidity Code (3). A code representing circumstances or conditions as the cause of the injury, poisoning, or other adverse effects recorded as a diagnosis.

External Cause of Morbidity Code (1), should indicate the nature of the adverse effect. External Cause of Morbidity Codes (2) and (3), are used for secondary to the primary code. No more than three (3) external cause of morbidity codes may be reported. Must be a valid ICD-10-CM cause of morbidity code for the reporting period. An external cause of morbidity code cannot be used more than once for each hospitalization reported. The code must be entered with use of a decimal point that is included in the valid code. Alpha characters must be in upper case.

(63) Emergency Department (ED) Date of Arrival. The date the patient registered in the Emergency Department if the visit results in an inpatient admission to the reporting facility. A ten (10) character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 01 to 12, DD represents numbered days of the month from 01 to 31, and YYYY represents the year in four (4) digits. Admission date must equal or precede the discharge date. Use 0000-00-00 for patients not admitted through the Emergency Department. A required entry.

(64) Emergency Department (ED) Hour of Arrival. The hour on a 24-hour clock during which the patient's registration in the emergency department occurred. A required entry. Use 99 where the patient was not admitted through the emergency department or where efforts to obtain the information have been unsuccessful. Must be two (2) digits as follows:

A.M. HOURS

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

P.M. HOURS

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

(65) Condition Code. A two-character code that describes patients admitted to the inpatient facility after receiving treatment in the facility's emergency department. Do not use this code for patients admitted to the hospital through the ED when the registration department is closed. Report using the two-character indicator code 'P7'. Otherwise zero fill using "00." A required field.

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

59E-7.029 Patient Data Release.

(1) Agency records, public records under Chapter 119, F.S. (Florida's Public Records Law), are available for public inspection during normal business hours. Copies of such records may be obtained upon request and upon payment of the cost of copying.

(2) Patient-specific records collected by the Agency pursuant to Rules 59E-7.021-.030, F.A.C., are exempt from disclosure pursuant to Section 408.061(7), F.S., and shall not be released unless modified to protect patient confidentiality as described in paragraph (2)(a) below and released in the manner described in paragraphs (2)(c) and (2)(d).

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

1. Patient Control Number as assigned by the facility. Delete.
2. Patient Social Security Number. Delete.
3. Patient Birth Date. Substitute age in years and an indicator of Age < 29 Days except for persons 100 and older, substitute age > 100 years.
4. Admission Date. Delete.
5. Discharge Date. Substitute quarters 1-4. (discharge month cannot be substituted)
6. Principal Procedure Date. Days from admission to Principal Procedure will be substituted.
7. Other Procedure Date. Days from admission to Other Procedure will be substituted.
8. Infant Linkage ID. Delete.
9. Medical or Health Record Number. Delete.
10. ED Date of Arrival. Visit Time Hours (VTH) will be substituted. The VTH will calculate the number of hours spent at the ED from registration to discharge.

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

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

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

(3) Aggregate reports derived from patient-specific hospital records collected pursuant to Rules 59E-7.021 through 59E-7.030, F.A.C., are public records and shall be released as described in this rule, provided that the aggregate reports do not include the patient control number as assigned by the facility, patient social security number, record linkage number, patient birth date, admission date, discharge date, principal procedure date, ED date of arrival other procedure date, infant linkage identifier or medical or health record number and provided the aggregate reports contain the combination of five or more records for any data disclosed.

Rulemaking Authority 408.15(8) FS. Law Implemented 408.061 FS. History—New 1-1-10, Formerly 59E-7.015 Amended 01-1-18.

59E-7.030 General Provisions.

Hospitals submitting inpatient discharge data pursuant to the provisions contained in these rules shall be directed by the following specific general provisions for inpatient data reporting.

(1) Any inpatient who is transferred or discharged from the acute care setting into a rehabilitative care distinct part unit or free standing hospital, must be reported as a separate record from the patients acute care record. The acute care discharge record is assigned data type one (1), and the comprehensive rehabilitative therapy discharge record is assigned data type two (2).

(2) If inpatients are administratively transferred or formally discharged from the acute care setting into a distinct-part Medicare certified skilled nursing unit or to hospice care, reporting accountability ceases at the time of discharge or transfer. Patient's receiving sub-acute care in these setting are excluded from inpatient reporting requirements.

(3) Observation patients are not included in the inpatient reported unless admitted to the hospital as an inpatient.

Rulemaking Authority 408.061(1)(e), 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History—New 1-1-10, Formerly 59E-7.016, Amended 01-1-18.