

59E-7.014 Inpatient Data Format - Data Elements, Codes and Standards.

(1) **HEADER RECORD.** The first record in the data file shall be a header record containing the information described below.

(a) **Transaction Code.** Enter Q for a calendar quarter report or S for a report period other than a calendar quarter where the special report is requested or authorized by the Agency to receive data corrections. A required field.

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

(c) **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.

(d) **Data Type.** Enter PD10-1 for Inpatient Data. A required field.

(e) **Submission Type.** Enter I or R where I indicates an initial submission or resubmission of previously rejected data, R indicates a replacement submission of previously processed and accepted inpatient data where resubmission has been requested or authorized by the Agency. A required field.

(f) **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.

(g) **AHCA Hospital Number.** Enter the identification number of the hospital as assigned by AHCA for reporting purposes. A valid identification number must contain at least eight (8) digits and no more than twelve (12) digits. A required field.

(h) **Organization Name.** Enter the name of the hospital that performed the inpatient service(s) represented by the data, and which is responsible for reporting the data. All questions regarding data accuracy and integrity will be referred to this entity. Up to a forty-character field. A required field.

(i) **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.

(j) **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 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.

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

(l) **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.

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

(n) **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.

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

(2) **INDIVIDUAL DATA RECORDS.** All data elements and data element codes listed below shall be reported consistent with the records of the reporting entity. Data elements and codes are listed with a description of the data to be reported and data standards.

(a) **AHCA Hospital Number.** Enter the identification number of the hospital as assigned by AHCA for reporting purposes. A valid identification number must contain at least eight (8) digits and no more than twelve (12) digits. A required field.

(b) **Record Identification 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 storage and retrieval of individual case records. Up to seventeen (17) characters. Duplicate record identification numbers are not permitted. A required field. The hospital must maintain a key list to locate actual records upon request by AHCA.

(c) **Patient Social Security Number.** Enter the social security number (SSN) of the patient receiving treatment. The SSN is a nine (9) digit number issued by the Social Security Administration. Reporting 000000000 is acceptable for newborns and infants up to two (2) years of age at admission who do not have a SSN. Reporting 777777777 is acceptable for those patients where efforts to obtain the SSN have been unsuccessful and the patient is two (2) years of age or older and not known to be from a country other than the United States (U.S.). Reporting 555555555 is acceptable for non-U.S. citizens who have not been issued SSNs. One SSN; one inpatient. DO NOT share SSNs in this field. A required entry.

(d) **Patient Race or Ethnicity.** Self-designated by the patient or patient's parent or guardian except code 8 indicating no response

may be reported where efforts to obtain the information from the patient or from the patient's parent or guardian have been unsuccessful. A required entry. Must be a one (1) digit code as follows:

1. 1 – American Indian or Alaska Native
2. 2 – Asian or Pacific Islander
3. 3 – Black or African American
4. 4 – White
5. 5 – White Hispanic
6. 6 – Black Hispanic
7. 7 – Other-Use if the patient's self-designated race or ethnicity is not described by the above categories.
8. 8 – No Response-Use if the patient refuses or fails to disclose.

(e) 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. Age greater than one hundred twenty (120) years is not permitted unless verified by the reporting entity. A birth date after the discharge date is not permitted. A required entry.

(f) Patient Gender. The gender of the patient at admission. A required entry. Must be a one (1) digit code as follows:

1. 1 – Male
2. 2 – Female
3. 3 – Unknown – Use where efforts to obtain the information have been unsuccessful or where the patient's gender cannot be determined due to a medical condition.

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

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

1. 1 – Emergency – The patient requires immediate medical intervention as a result of severe, life-threatening or potentially disabling conditions.
2. 2 – Urgent – The patient requires attention for the care and treatment of a physical or mental disorder.
3. 3 – Elective – The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
4. 4 – Newborn – Use of this code requires the use of special Source of Admission codes. (See also subparagraphs 59E-7.014(2)(i)10.-13., F.A.C.)
5. 5 – Trauma Center – Trauma activation at a State of Florida designated trauma center.

(i) Source of Admission. Must be a two (2) digit code as follows, where codes 10 through 13 are to be used for newborn admissions, codes 1 through 8 are to be used for any admission that is not a newborn, code 9 is used where the source of admission is not known, and code 14 is used where the Source of Admission is other than code 1 through code 13. A required field.

1. 01 – Physician referral – The patient was admitted to this facility upon the recommendation of the patient's personal physician.
2. 02 – Clinic referral – The patient was admitted to this facility upon recommendation of this facility's clinic physician.
3. 03 – HMO referral – The patient was admitted to this facility upon the recommendation of a health maintenance organization physician.
4. 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.
5. 05 – Transfer from a skilled nursing facility – The patient was admitted to this facility from a skilled nursing facility where the patient was at a skilled level of care.
6. 06 – Transfer from another health care facility – The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility.
7. 07 – Emergency Room – The patient was admitted to this facility through the emergency room upon recommendation of an emergency room physician or other physician.
8. 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.
9. 09 – Information Not Available – The means by which the patient was admitted to this hospital is not known.

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

10. 10 – Normal delivery – A baby delivered without complications.
11. 11 – Premature delivery – A baby delivered with time or weight factors qualifying it for premature status.
12. 12 – Sick Baby – A baby delivered with medical complications, other than those relating to premature status.
13. 13 – Extramural – A newborn born in a non-sterile environment.
14. 14 – Other – The source of admission is not described by subparagraphs 1. through 13., above.

(j) Admission Date. The date the patient was admitted 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. A required entry.

(k) 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.

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

1. 01 – Discharged to home or self-care (with or without planned outpatient medical care)
2. 02 – Discharged to a short-term general hospital
3. 03 – Discharged to a skilled nursing facility
4. 04 – Discharged to an intermediate care facility
5. 05 – Discharged to another type of institution (cancer or children’s hospital or distinct part unit)
6. 06 – Discharged to home under care of home health care organization
7. 07 – Left this hospital against medical advice (AMA) or discontinued care
8. 08 – Discharged home under care of home IV provider on IV medications
9. 20 – Expired
10. 50 – Discharged to hospice – home
11. 51 – Discharged to hospice – medical facility
12. 62 – Discharged to an inpatient rehabilitation facility including rehabilitation distinct part units of a hospital.
13. 63 – Discharged to a Medicare certified long term care hospital.
14. 65 – Discharged to a psychiatric hospital including psychiatric distinct part units of a hospital.

(m) Principal Payer Code. Describes the expected primary source of reimbursement for services rendered based on the patient’s status at discharge or the time of reporting. Report charity as defined in subsection 59E-7.011(2), F.A.C. A required entry. Must be a one (1) character alpha field using upper case as follows:

1. A – Medicare
2. B – Medicare HMO or Medicare PPO
3. C – Medicaid
4. D – Medicaid HMO
5. E – Commercial Insurance
6. F – Commercial HMO
7. G – Commercial PPO
8. H – Workers’ Compensation
9. I – CHAMPUS
10. J – VA
11. K – Other State/Local Government
12. L – Self Pay/Under-insured – No third party coverage or less than 30% estimated insurance coverage.
13. M – Other
14. N – Charity
15. O – KidCare – Includes Healthy Kids, MediKids and Children’s Medical Services.

(n) 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-9-CM or ICD-10-CM code for the reporting period. Inconsistency between the principal diagnosis code and patient gender must be verified by the reporting entity. Inconsistency

between the principal diagnosis code and patient age must be verified by the reporting entity. 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 and without use of a zero or zeros that are not included in the valid code. A required entry.

(o) 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 injury codes. Report external cause of injury codes as described in paragraph (ww) below. No more than thirty (30) other diagnosis codes may be reported. Less than thirty (30) entries or no entry is permitted consistent with the records of the reporting entity. Must contain a valid ICD-9-CM code or valid ICD-10-CM code for the reporting period. Inconsistency between the other diagnosis code and patient gender must be verified by the reporting entity. Inconsistency between the other diagnosis code and patient age must be verified by the reporting entity. 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 and without use of a zero or zeros that are not included in the valid code.

(p) 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 (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 Injury Code (1), Present on Admission Indicator for External Cause of Injury Code (2), and Present on Admission Indicator for External Cause of Injury Code (3). A code differentiating whether the condition represented by the corresponding Principal Diagnosis Code (n), Other Diagnosis Code (o)(1) through (30), and External Cause of Injury Code (ww)(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 if the corresponding code is reported or a blank field may be reported when present on admission is not applicable. Present on Admission Indicator must be a one (1) character alpha code as follows:

1. Y – Yes – Present at the time that the order for inpatient admission occurs.
2. N – No – Not present at the time that the order for inpatient admission occurs.
3. U – Unknown – Documentation is insufficient to determine if condition is present on admission.
4. W – Clinically Undetermined – Provider is unable to clinically determine whether condition was present on admission or not.

(q) 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-9-CM or ICD-10-CM procedure code for the reporting period. If a principal procedure date is reported, a valid principal procedure code must be reported. Inconsistency between the principal procedure code and patient gender must be verified by the reporting entity. Inconsistency between the principal procedure code and patient age must be verified by the reporting entity. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code.

(r) 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 four (4) days prior to the admission date and not later than the discharge date.

(s) 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 no principal procedure is 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 consistent with the records of the reporting entity. Must be a valid ICD-9-CM or ICD-10-CM procedure code for the reporting period. Inconsistency between the procedure code and patient gender must be verified by the reporting entity. Inconsistency between the procedure code and patient age must be verified by the reporting entity. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code.

(t) 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 (s)(1) through (30) is reported. No entry is permitted if no procedure is reported consistent with the records of the reporting entity. 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 four (4) days prior to the admission date and not later than the discharge date.

(u) Attending Physician 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 US. A required entry.

(v) Operating or Performing Physician 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 physician may be the attending physician. For military physicians not licensed in Florida, use US. No entry is permitted if no principal procedure is reported consistent with the records of the reporting entity.

(w) Other Operating or Performing Physician 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 physician or performed a secondary procedure. The other operating or performing physician must not be reported as the operating or performing physician. The other operating or performing physician may be the attending physician. For military physicians not licensed in Florida, use US. No entry is permitted consistent with the records of the reporting entity.

(x) Room and Board Charges. Routine service charges incurred for accommodations. Report charges for revenue codes 11X through 16X as used in the UB-92 or UB-04. Charges to be reported in dollars numerically, 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.

(y) Nursery Charges. Accommodation charges for nursing care to newborn and premature infants in nursery. Report charges for

revenue code 17X as used in the UB-92 or UB-04 excluding Level III charges. Charges to be reported in dollars numerically, 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.

(z) Level III Nursery Charges. Accommodation charges for nursing care to newborn and premature infants for Level III nursery charges. Report charges for revenue code 173 (Level III) as used in the UB-92 or UB-04. Charges to be reported in dollars numerically, 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.

(aa) 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-92 or UB-04. Reported in dollars numerically, 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.

(bb) 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-92 or UB-04. Reported in dollars numerically, 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.

(cc) Pharmacy Charges. Charges for medication. Report charges for revenue codes 25X and 63X as used in the UB-92 or UB-04. Reported in dollars numerically 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.

(dd) 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-92 or UB-04. Reported in dollars numerically 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.

(ee) 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-92 or UB-04. Reported in dollars numerically 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.

(ff) 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-92 or UB-04. Reported in dollars numerically 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.

(gg) Cardiology Charges. Facility charges for cardiac procedures rendered such as, but not limited to, heart catheterization or coronary angiography. Reported in dollars numerically without dollar signs or commas, excluding cents. Report charges for revenue code 48X as used in the UB-92 or UB-04. Report zero (0) if there are no cardiology charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(hh) 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-92 or UB-04. Reported in dollars numerically 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.

(ii) Operating Room Charges. Charges for the use of the operating room. Report charges for revenue code 36X as used in the UB-92 or UB-04. Reported in dollars numerically 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.

(jj) Anesthesia Charges. Charges for anesthesia services by the facility. Report charges for revenue code 37X as used in the UB-92 or UB-04. Reported in dollars numerically 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.

(kk) Recovery Room Charges. Charges for the use of the recovery room. Report charges for revenue code 71X as used in the UB-92 or UB-04. Reported in dollars numerically 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.

(ll) Labor Room Charges. Charges for labor and delivery room services. Report charges for revenue code 72X as used in the UB-92 or UB-04. Reported in dollars numerically 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.

(mm) Emergency Room Charges. Charges for medical examinations and emergency treatment. Report charges for revenue code 45X as used in the UB-92 or UB-04. Reported in dollars numerically 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.

(nn) Trauma Response Charges. Charges for a trauma team activation. Report charges for revenue code 68X used in the UB-92 or UB-04. Reported in dollars numerically 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.

(oo) 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-92 or UB-04. Reported in dollars numerically 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.

(pp) 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-92 or UB-04. Reported in dollars numerically 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.

(qq) Oncology. Charges for treatment of tumors and related diseases. Excludes therapeutic radiology services reported in radiology and other imaging services (ff). Report charges for revenue code 28X as used in the UB-92 or UB-04. Reported in dollars numerically 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.

(rr) Physical and Occupational Therapy Charges. Report charges for physical, occupational or speech therapy in revenue codes 42X through 44X as used in the UB-92 or UB-04. Reported in dollars numerically 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.

(ss) Other Charges. Other facility charges not included in paragraphs (x) to (rr) above. Include charges that are not reflected in any of the preceding specific revenue accounts in the UB-92 or UB-04. DO NOT include charges from revenue codes 96X, 97X, 98X, or 99X in the UB-92 or UB-04 for professional fees and personal convenience items. Reported in dollars numerically 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.

(tt) 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 paragraphs (x) through (ss) must equal total charges, plus or minus ten (10) dollars. Reported in dollars numerically 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.

(uu) 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 77777777 for the mother's SSN is acceptable for those patients where efforts to obtain the mother's SSN have been unsuccessful and the mother is not known to be from a country other than the United States. Reporting 55555555 is acceptable if the infant's mother is not a U.S. Citizen and has not been issued a SSN. Infants in the custody of the State of Florida or adoptions, use 33333333 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. If the patient is two (2) years of age or older, the field is zero filled. A required entry.

(vv) 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-9-CM code or valid ICD-10-CM code for the reporting period. Inconsistency between the admitting diagnosis code and patient gender must be verified by the reporting entity. Inconsistency between the admitting diagnosis code and patient age must be verified by the reporting entity. The code must be entered with use of a decimal point that is included in the valid code and without use of a zero or zeros that are not included in the valid code. A required entry.

(ww) External Cause of Injury Code (1), External Cause of Injury Code (2), and External Cause of Injury Code (3). A code representing circumstances or conditions as the cause of the injury, poisoning, or other adverse effects recorded as a diagnosis. No more than three (3) external cause of injury codes may be reported. Less than three (3) or no entry is permitted consistent with the records of the reporting entity. Entry must be a valid ICD-9-CM or ICD-10-CM cause of injury code for the reporting period. An external cause of injury 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 and without use of a zero or zeros that are not included in the valid code.

(xx) Emergency Department 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:

1. 00 – 12:00 midnight to 12:59
2. 01 – 01:00 to 01:59
3. 02 – 02:00 to 02:59
4. 03 – 03:00 to 03:59
5. 04 – 04:00 to 04:59
6. 05 – 05:00 to 05:59
7. 06 – 06:00 to 06:59
8. 07 – 07:00 to 07:59
9. 08 – 08:00 to 08:59
10. 09 – 09:00 to 09:59
11. 10 – 10:00 to 10:59
12. 11 – 11:00 to 11:59
13. 12 – 12:00 noon to 12:59
14. 13 – 01:00 to 01:59
15. 14 – 02:00 to 02:59
16. 15 – 03:00 to 03:59
17. 16 – 04:00 to 04:59
18. 17 – 05:00 to 05:59
19. 18 – 06:00 to 06:59
20. 19 – 07:00 to 07:59
21. 20 – 08:00 to 08:59
22. 21 – 09:00 to 09:59
23. 22 – 10:00 to 10:59
24. 23 – 11:00 to 11:59
25. 99 – Unknown.

(3) 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.

Specific Authority 408.061(1)(e), 408.15(8) FS. Law Implemented 408.061 FS. History--New 12-15-96, Amended 7-11-01, 7-12-05, 5-22-07.