

CHAPTER 59B-9 AMBULATORY AND EMERGENCY DEPARTMENT DATA COLLECTION

59B-9.010 Purpose of Ambulatory Patient Data Reporting.

The reporting of ambulatory patient data will provide a statewide integrated database that includes ambulatory surgery and hospital emergency department services for the assessment of variations in utilization, disease surveillance, access to care and cost trends. The amendments appearing herein are effective with the reporting period starting January 1, 2005.

Rulemaking Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History—New 9-6-93, Formerly 59B-7.010, Amended 6-29-95, Amended 12-28-98, 2-25-02, 4-18-04, Repealed 1-1-10.

59B-9.011 Submission of Ambulatory Patient Data.

(1) The following entities shall submit ambulatory patient data and reports to the Agency for Health Care Administration (AHCA or agency):

- (a) All licensed short-term acute care hospitals;
- (b) All licensed ambulatory surgical centers as defined in Section 395.002(3), F.S.;
- (c) All lithotripsy centers defined in Section 408.07, F.S.;
- (d) All cardiac catheterization laboratories defined in Section 408.07, F.S.

(2) For purposes of Rules 59B-9.010 through 59B-9.023, F.A.C., “ambulatory centers” refers to the ambulatory patient data reporting facilities and providers in subsection (1) above.

(3) Each facility in paragraph (1)(a) above shall submit a separate report for each location per Rule 59A-3.203, F.A.C. Each facility in paragraph (1)(b) above shall submit a separate report for each location per Rule 59A-5.003, F.A.C. Each facility or provider in paragraph (1)(c) or (1)(d) above shall submit a separate report for each separate location.

(4) All ambulatory centers performing the services set forth in Rules 59B-9.011 through 59B-9.023, F.A.C., shall submit ambulatory patient data as set forth in Rules 59B-9.018 and 59B-9.019, F.A.C., unless the reporting entity meets the criteria listed in subsection 59B-9.011(6), F.A.C., below.

(5) Any ambulatory center which has a total of 200 or more patient visits per Rule 59B-9.014, F.A.C., for the reporting period is required to report data as set forth in Rules 59B-9.018 and 59B-9.019, F.A.C.

(6) Ambulatory Centers with fewer than 200 patient visits in a quarter, must have the entity’s Chief Executive Officer certify to the Agency in writing, that the ambulatory center has fewer than 200 patient visits per Rule 59B-9.014, F.A.C., for the reporting period, and the certification is to be received at the Agency office in Tallahassee on or prior to the deadline for submission of the report. This is not a one time letter, but must be submitted for each quarter where there were fewer than 200 visits.

(7) If requested by Agency staff, all ambulatory centers shall provide access to or at the option of Agency staff, information from the medical records underlying and documenting the ambulatory patient data submitted, as well as other patient related documentation deemed necessary by the Agency to conduct complete ambulatory patient data audits subject to the limitations as set forth in Section 408.061(1)(d), F.S.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063, 408.07, 408.08 FS. History—New 9-6-93, Formerly 59B-7.011, Amended 6-29-95, 12-28-98, 7-11-01, 2-25-02, Repealed 1-1-10.

59B-9.013 Definitions.

(1) “CPT” means Current Procedural Terminology and refers to a coding system established by the American Medical Association to describe physician services which is published annually in Physicians’ Current Procedural

Terminology manual which is incorporated by reference.

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

(3) “Charity” means medical care provided by a health care entity to a person who has insufficient resources or assets to pay for needed medical care without utilizing his resources which are required to meet his basic need for shelter, food, or clothing. No patient shall be considered charity care whose family income, as applicable for the twelve (12) months preceding the determination, exceeds 150 percent of the federal poverty guidelines, unless the amount of health care charges due from the patient exceeds 25 percent of annual family income.

(4) “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 unless they are admitted.

(5) “Visit” means a face to face encounter between a health care provider and a patient who is not formally admitted as an inpatient in an acute care hospital setting at the time of the encounter or who is not admitted to the same facility’s acute care hospital setting immediately following the encounter as described in subsection 59B-9.015(3), F.A.C. Visits which require the patient to appear in an ambulatory setting prior to the actual procedure (even if this occurs one or more days before the procedure) shall be counted as one visit.

(6) Each “Ambulatory Center” is required to report ambulatory patient data. For the purposes of this rule, ambulatory center includes freestanding ambulatory surgery centers, short-term acute care hospitals, lithotripsy centers, and cardiac catheterization laboratories.

(7) “Attending Physician” means a licensed medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced registered nurse practitioner who has primary responsibility for the patient’s medical care and treatment during the visit or who certifies as to the medical necessity of the services rendered. The attending physician may be the operating or performing physician. The attending physician may be an emergency room physician or other specialist.

(8) “Operating or Performing Physician” means a licensed medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced registered nurse practitioner who has primary responsibility for the surgery or procedure performed. The operating or performing physician may be the attending physician.

(9) “Other Physician” means a licensed medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced registered nurse practitioner who rendered care to the patient other than the attending physician or the operating or performing physician.

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

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History—New 9-6-93, Formerly 59B-7.013, Amended 6-29-95, 12-28-98, 7-11-01, 2-25-02, 4-18-04, Repealed 1-1-10.

59B-9.014 Schedule for Submission of Ambulatory Patient Data and Extensions.

(1) Ambulatory centers shall report ambulatory patient data, as described in subsection 59B-9.015(2) and Rule 59B-9.018, F.A.C., according to the following schedule:

(a) Each report covering patient visits ending between January 1 and March 31, inclusive of each year, shall be submitted no later than June 10 of the calendar year during which the visit occurred.

(b) Each report covering patient visits ending between April 1 and June 30, inclusive of each year, shall be submitted no later than September 10 of the calendar year during which the visit occurred.

(c) Each report covering patient visits ending between July 1 and September 30, inclusive of each year, shall be submitted no later than December 10 of the calendar year during which the visit occurred.

(d) Each report covering patient visits ending between October 1 and December 31, inclusive of each year, shall be submitted no later than March 10 of the calendar year following the year in which the visit occurred.

(2) Extensions to the due dates in subsection 59B-9.014(1), F.A.C., above shall be granted by Agency staff for thirty (30) days in response to a written request if received prior to the due date, and provided that the delay is due to

unforeseen and unforeseeable factors beyond the control of the reporting entity. These factors must be specified in the letter requesting the extension together with documentation of efforts undertaken to meet the filing requirements. For re-submissions, a fourteen (14) calendar day extension will be granted if requested in writing prior to the due date as specified in the letter accompanying the resubmitted request.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.15(11) FS. History—New 9-6-93, Formerly 59B-7.014, Amended 6-29-95, 4-18-04, Repealed 1-1-10.

59B-9.015 Reporting Instructions.

(1) Ambulatory centers shall submit ambulatory patient data according to Rule 59B-9.018, F.A.C.

(2) Ambulatory centers shall report data for:

(a) All non-emergency visits in which surgery services were performed and the services provided correspond to a Current Procedural Terminology (CPT) code 10000 through 69999 or 93500 through 93599. Codes must be valid in the current or the immediately preceding year's code book to be accepted.

(b) All emergency department visits in which emergency department registration occurs and the patient is not admitted for inpatient care at the reporting entity. Include all visits for which a billing record is created.

(3) Ambulatory centers shall exclude records of any patient visit in which the outpatient and inpatient billing record is combined because the patient was admitted to inpatient care within a facility at the same location per Rule 59A-3.203, F.A.C. Report one record for each visit, except pre-operation visits may be combined with the record of the associated ambulatory surgery visit. See subsection 59B-9.013(5), F.A.C.

(4) For each patient visit, ambulatory centers shall report all services provided using procedural codes specified in subsection 59B-9.018(2), F.A.C.

(5) Ambulatory centers shall submit ambulatory patient data reports to the agency using one of the following methods described in paragraph (a) or in (b) below except that for patient visits ending on or after January 1, 2006, the methods described in paragraph (b) must not be used unless an exception is requested by the ambulatory center due to extraordinary or hardship circumstances and use of method (b) is approved by the agency. Use of method (a) must be approved by the agency for any patient visits ending prior to January 1, 2006.

(a) Internet Transmission. The Internet address established for receipt of ambulatory patient data is www.fdhc.state.fl.us. Reports sent to the Internet address shall be electronically transmitted with the ambulatory data in a text (XML) file using the Ambulatory Patient Data XML Schema available at www.fdhc.state.fl.us. The Ambulatory Patient Data XML Schema is incorporated by reference. The data in the text file shall contain the data elements, codes, and standards required in Rule 59B-9.018, F.A.C.

(b) CD-ROM or diskettes shall be sent to the agency's mailing address: Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308. Attention: Florida Center for Health Information and Policy Analysis. Electronic media specifications are:

1. MS-DOS formatted.

2. Text File (XML) using the Ambulatory Patient Data XML Schema available at www.fdhc.state.fl.us.

3. Type: 3.5" diskette, 1.4MB, hd; or CD-ROM.

4. FILENAME: (e.g., AS10QYY.XML) The 5th position shall contain the quarter (1-4) and the 6th and 7th position shall contain the year. XML indicates an XML text file.

5. Only one (1) file per diskette set or CD-ROM is allowable. Data requiring more than one diskette shall have the same internal file name. Data requiring more than one (1) diskette shall be externally labeled 1 of x, 2 of x, etc. (x = total number of diskettes).

(6) Ambulatory centers submitting diskettes shall affix the following external identification, or for CD-ROM, use a standard CD-ROM external label with the following information:

(a) Ambulatory center name;

(b) AHCA ambulatory center identification number in the AHCA format;

(c) Reporting period;

- (d) Number of records excluding the header record and the trailer record;
- (e) Diskette or CD-ROM Filename as in subsection 59B-9.015(5), F.A.C., above; and
- (f) The description: "AMBULATORY PATIENT DATA".

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History—New 9-6-93, Formerly 59B-7.015, Amended 6-29-95, 12-28-98, 1-4-00, 7-11-01, 2-25-02, 4-18-04, Repealed 1-1-10.

59B-9.016 Notice of Reporting Deficiencies and Response.

(1) Within sixty (60) days after the due date or date of receipt, whichever is later of ambulatory patient data, agency staff shall determine and notify the ambulatory center whether the report is complete and conforms to the applicable rule instructions and data standards per Rules 59B-9.018-.020, F.A.C.

(2) Written notification shall be provided by certified mail, electronic mail, or FAX to an ambulatory center in the event the staff determines the data is incomplete or nonconforming. The notice shall clearly indicate the deficiencies found, and the time by which a corrected or modified report must be received in the agency's office.

(3) An ambulatory center shall have fourteen (14) calendar days following receipt of notice, to return to the agency's office the requested corrected data or completed certification pages.

Specific Authority 408.15(8) FS. Law Implemented 408.006(5), 408.061 FS. History—New 9-6-93, Formerly 59B-7.016, Amended 6-29-95, 7-11-01, Repealed 1-1-10.

59B-9.017 Certification and Audit Procedures.

(1) All ambulatory centers submitting data in compliance with Rules 59B-9.010 through 59B-9.022, F.A.C., shall certify that the data submitted for each reporting period is accurate. These certification pages are sent by the agency to the reporting entity with summary reports generated by the agency using submitted data. The certification shall be submitted to the agency's office at the address in subsection (3) below using the Certification of Ambulatory Patient Data Form described in subsection (3) below or the Certification of Ambulatory Patient Data Form shall be submitted by electronic mail to SCHSdata@fdhc.state.fl.us using an agency authorized electronic signature.

(2) The Chief Executive Officer and Chief Financial Officer shall state in writing that a complete review was accomplished to assure the accuracy of the data and that to the best of their knowledge and belief, the data submitted are accurate and complete.

(3) Form APD1 is titled "Certification of Ambulatory Patient Data", may be obtained by writing to The Agency for Health Care Administration, Ambulatory Patient Data Section, 2727 Mahan Drive, Fort Knox Building #3, Tallahassee, Florida 32308-5403. The effective date of the form is July 1, 1995. Form APD1 is incorporated by reference.

(4) The agency shall to the extent practical, apply the same audit standards and use the same audit procedures for all ambulatory centers or audit a random sample of ambulatory centers. The agency will notify each ambulatory center of any possible errors discovered by audit and request that the ambulatory center either correct the data or verify that the data is complete and correct. The notice shall indicate that the ambulatory center must return corrected data if there are errors and certify the data within ninety (90) days of receipt of the notice, or the ambulatory center Chief Executive Officer must verify by signature that the previously submitted and certified data is complete and correct within ninety (90) days of receipt of the notice. The notice shall clearly indicate that the ambulatory center may be subject to penalties pursuant to Rule 59B-9.022, F.A.C.

Specific Authority 408.15(8) FS. Law Implemented 408.061, 408.08(1), 408.08(5), 408.15(11) FS. History—New 9-6-93, Formerly 59B-7.017, Amended 6-29-95, 7-11-01, Repealed 1-1-10.

59B-9.018 Ambulatory Patient 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. If diskettes are submitted, the header record must be placed as the first record on the first diskette of the data set.

(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.

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

(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.

(d) Data Type – Enter AS10 for Ambulatory Data.

(e) Submission Type – Enter I, R, or C where I indicates an initial submission of data or resubmission of previously rejected data, R indicates a replacement submission of previously processed and accepted ambulatory patient data, and C indicates an individual record correction or set of individual record corrections where submission of a correction or corrections is requested or authorized by the agency.

(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 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits.

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

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

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

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

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

(l) Contact Person Address – Enter the mailing address of the contact person. Up to a forty character field.

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

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

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

(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 Ambulatory Center Number – An identification number assigned by AHCA for reporting purposes. The number must match the ambulatory center number recorded on the CD-ROM or diskette external label and header record. A valid identification number must contain at least eight digits and no more than 10 digits. A required entry.

(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 characters. A required entity. Duplicate record identification numbers are not permitted.

(c) Patient Social Security Number – The social security number (SSN) of the patient. A nine digit field to facilitate retrieval of individual case records, to be used to track multiple patient visits, and for medical research. Reporting 000000000 is acceptable for newborns and infants up to 2 years of age who do not have a SSN. For

patients not from the United States, use 555555555 if a SSN is not assigned. For those patients where efforts to obtain the SSN have been unsuccessful or where one is unavailable, and the patient is 2 years of age or older and not known to be from a country other than the United States, use 777777777. 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 have been unsuccessful. A required entry. Must be a one 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 character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits. Use 9999-99-99 where type of service is “2” and efforts to obtain the patient’s birth date have been unsuccessful. Age greater than 120 years is not permitted unless verified by the reporting entity. A birth date after the patient visit ending date is not permitted. A required entry.

(f) Patient Sex – The gender of the patient. A required entry. Must be a one digit code as follows:

1. 1 – Male.
2. 2 – Female.
3. 3 – Unknown shall be reported where efforts to obtain the information have been unsuccessful or where the patient’s sex cannot be determined due to a medical condition.

(g) Patient Zip Code – The five 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 Service Code – A code designating the type of service, either ambulatory surgery or emergency department visit. A required entry. Must be a one digit code as follows:

1. 1 – Ambulatory surgery, as described in paragraph 59B-9.015(2)(a), F.A.C.
2. 2 – Emergency department visit, as described in paragraph 59B-9.015(2)(b), F.A.C.

(i) Principal Payer Code – Describes the primary source of expected reimbursement for services rendered. A required entry. Must be a one character field using upper case as follows:

1. A – Medicare.
2. B – Medicare HMO.
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. No third party coverage.
13. M – Other.
14. N – Charity.
15. O – KidCare. Includes Healthy Kids, MediKids and Children’s Medical Services.
16. P – Unknown. Unknown shall be reported if principal payer information is not available and type of service

is “2” and patient status is “07”.

(j) Principal Diagnosis Code – The code representing the diagnosis chiefly responsible for the services performed during the visit. Must contain a valid ICD-9-CM or ICD-10-CM diagnosis code if type of service is “1” indicating ambulatory surgery. Must contain a valid ICD-9-CM or ICD-10-CM diagnosis code if type of service is “2” indicating an emergency department visit unless patient status is “07” indicating that the patient left against medical advice or discontinued care. A blank field is permitted if type of service is “2” and patient status is “07” consistent with the records of the reporting entity. If not space filled, must contain a valid ICD-9-CM diagnosis code or valid ICD-10-CM diagnosis code for the reporting period. Inconsistency between the principal diagnosis code and patient sex 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 visit 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.

(k) Other Diagnosis Code (1), Other Diagnosis (2), Other Diagnosis (3), Other Diagnosis (4), Other Diagnosis (5), Other Diagnosis (6), Other Diagnosis (7), Other Diagnosis (8), Other Diagnosis (9) – A code representing a diagnosis related to the services provided during the visit. If no principal diagnosis code is reported, another diagnosis code must not be reported. No more than nine other diagnosis codes may be reported. Less than nine entries or no entry is permitted consistent with the records of the reporting entity. If not space filled, must contain a valid ICD-9-CM code or valid ICD-10-CM code for the reporting period. Inconsistency between the diagnosis code and patient sex must be verified by the reporting entity. Inconsistency between the 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 visit 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.

(l) Principal CPT or HCPCS Procedure Code – A code representative of the services provided or procedures performed. Must contain a valid CPT code between 10000 and 69999, inclusive, or between 93500 and 93599, inclusive if type of service is “1” indicating ambulatory surgery. Must contain a valid HCPCS or CPT evaluation and management code if type of service is “2” indicating an emergency department visit and patient status is not “07.” Must contain a valid HCPCS or CPT evaluation and management code, or a blank field, consistent with the records of the reporting entity, if type of service is “2” indicating an emergency department visit and patient status is “07” indicating that the patient left against medical advice or discontinued care. If not space filled, must contain a valid CPT or HCPCS procedure code. Inconsistency between the principal procedure code and patient sex 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 five digits and valid for the reporting period.

(m) Other CPT or HCPCS Procedure Code (1), Other CPT or HCPCS Procedure Code (2), Other CPT or HCPCS Procedure Code (3), Other CPT or HCPCS Procedure Code (4), Other CPT or HCPCS Procedure Code (5), Other CPT or HCPCS Procedure Code (6), Other CPT or HCPCS Procedure Code (7), Other CPT or HCPCS Procedure Code (8), Other CPT or HCPCS Procedure Code (9) – A code representing a procedure or service provided during the visit. If no principal CPT or HCPCS procedure is reported, another CPT or HCPCS procedure code must not be reported. No more than nine other CPT or HCPCS procedure codes may be reported. Less than nine entries or no entry is permitted consistent with the records of the reporting entity. If not space filled, must be a valid CPT or HCPCS code. Inconsistency between the procedure code and patient sex 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 five digits and valid for the reporting period.

(n) Attending Physician Identification Number – The Florida license number of the attending physician as defined in subsection 59B-9.013(7), F.A.C. Report the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor or advanced registered nurse practitioner who had primary responsibility for the patient’s care during the visit. An alpha-numeric field of up to eleven characters. For military physicians not licensed in Florida, use US. Use NA if the patient was not treated by a medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced registered nurse practitioner. A required entry.

(o) Operating or Performing Physician Identification Number – The Florida license number of the operating or

performing physician as defined in subsection 59B-9.013(8), F.A.C. Report the medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced registered nurse practitioner who had primary responsibility for the surgery or procedure performed. The operating or performing physician may be the person reported in paragraph (n) above. An alpha-numeric field of up to eleven characters. For military physicians not licensed in Florida, use US. A blank or no entry is permitted consistent with the records of the reporting entity.

(p) Other Physician Identification Number – The Florida license number of another physician as defined in subsection 59B-9.013(9), F.A.C. Report a medical doctor, osteopathic physician, dentist, podiatrist, chiropractor, or advanced registered nurse practitioner who rendered care to the patient other than the person reported in paragraph (n) or (o) above. An alpha-numeric field of up to eleven characters. For military physicians not licensed in Florida, use US. A blank or no entry is permitted consistent with the records of the reporting entity.

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

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

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

(t) Radiology and Other Imaging Charges – Charges for the performance of diagnostic and therapeutic radiology services including computed tomography, mammography, magnetic resonance imaging, nuclear medicine, and chemotherapy administration of radioactive substances, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no radiology or computed tomography charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(u) Cardiology Charges – Facility charges for cardiac procedures rendered such as heart catheterization, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no cardiology charges. Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

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

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

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

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

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

(aa) Other Charges – Other facility charges not included in paragraphs (q) to (z) above, reported in dollars numerically without dollar signs or commas, excluding cents. Report 0 (zero) if there are no other charges.

Negative amounts are not permitted unless verified separately by the reporting entity. A required entry.

(bb) Total Gross Charges – The total of undiscounted charges for services rendered by the reporting entity, reported in dollars numerically without dollar signs or commas, excluding cents. Include charges for services rendered by the ambulatory center excluding professional fees. Zero (0) or negative amounts are not permitted unless verified separately by the reporting entity. Amounts exceeding 50000 must be verified separately by the reporting entity if type of service is “1” indicating ambulatory surgery. Amounts exceeding 100000 must be verified separately by the reporting entity if type of service is “2” indicating an emergency department visit. The sum of pharmacy charges, medical and surgical supply charges, laboratory charges, radiology and other imaging charges, cardiology charges, operating room charges, anesthesia charges, recovery room charges, emergency room charges, treatment or observation room charges, and other charges must equal total charges, plus or minus 10. A required entry.

(cc) Patient Visit Beginning Date – The date at the beginning of the patient’s visit for ambulatory surgery or the date at the time of registration in the emergency department. A ten character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits. Patient visit beginning date must equal or precede the patient visit ending date. A required entry.

(dd) Patient Visit Ending Date – The date at the end of the patient’s visit. A ten character field in the format YYYY-MM-DD where MM represents the numbered months of the year from 1 to 12, DD represents numbered days of the month from 1 to 31, and YYYY represents the year in four digits. Patient visit ending date must equal or follow the patient visit beginning date. Patient visit ending date must occur within the calendar quarter recorded on the CD-ROM or diskette external label and header record. A visit exceeding 2 days as determined by the patient visit beginning date and patient visit ending date must be verified by the reporting entity. A blank field is not permitted unless type of service is “2” indicating an emergency department visit and patient status is “07” indicating the patient left against medical advice or discontinued care.

(ee) Hour of Arrival – The hour on a 24-hour clock during which the patient’s visit for ambulatory surgery began or during which registration in the emergency department occurred. A required entry. Use 99 where efforts to obtain the information have been unsuccessful. Must be two digits as follows:

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.

(ff) Patient's Reason for Visit ICD-CM Code (Admitting Diagnosis) – The code representing the patient's chief complaint or stated reason for seeking care. Must contain a valid ICD-9-CM code or valid ICD-10-CM code for the reporting period if type of service is "2" indicating an emergency department visit unless the patient fails to disclose or the information is unavailable. A blank field is permitted if the patient fails to disclose or efforts to obtain the information have been unsuccessful consistent with the records of the reporting entity. If not space filled, must contain a valid ICD-9-CM or ICD-10-CM diagnosis code. 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. Space fill if type of service is "1" indicating ambulatory surgery.

(gg) Principal ICD-CM Procedure Code – The code representing the procedure or service most related to the principal diagnosis. A blank field is permitted if type of service is "1" indicating ambulatory surgery. A blank or no entry is permitted consistent with the records of the reporting entity if type of service is "2" indicating an emergency department visit. If not space filled, must contain a valid ICD-9-CM or ICD-10-CM procedure code for the reporting period. Inconsistency between the principal procedure code and patient sex 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.

(hh) Other ICD-CM Procedure Code (1), Other ICD-CM Procedure Code (2), Other ICD-CM Procedure Code (3), Other ICD-CM Procedure Code (4) – A code representing a procedure or service provided during the visit. If no principal ICD-CM procedure is reported, another ICD-CM procedure code must not be reported. No more than four other ICD-CM procedure codes may be reported. A blank or no entry is permitted if type of service is "1." Less than four or no entry is permitted if type of service is "2" consistent with the records of the reporting entity. If not space filled, must be a valid ICD-9-CM or ICD-10-CM procedure code for the reporting period. Inconsistency between the procedure code and patient sex 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.

(ii) 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 external cause of injury codes may be reported. Less than three or no entry is permitted consistent with the records of the reporting entity. If not space filled, 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 visit 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.

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

1. 01 – Discharged to home or self care (with or without planned outpatient medical care).

2. 02 – Transferred to a short-term general hospital.

3. 03 – Transferred to a skilled nursing facility.

4. 04 – Transferred to an intermediate care facility.

5. 05 – Transferred to another type of institution (psychiatric, cancer or children's hospital or distinct part unit).

6. 06 – Discharged to home under care of home health care organization.

7. 07 – Left against medical advice or discontinued care.

8. 08 – Discharged to home under care of home IV provider.

9. 20 – Expired.

10. 50 – Discharged to hospice – home.

11. 51 – Transferred to hospice – medical facility.

12. 62 – Transferred to an inpatient rehabilitation facility including distinct part units of a hospital.

(3) Trailer Record: The last record in the data file shall be a trailer record and must accompany each data set. If diskettes are submitted, the trailer record must be placed as the last record on the last diskette of the data set. One data element, number of records, must be entered in the trailer record. Report 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 408.15(8) FS. Law Implemented 408.061, 408.062, 408.063 FS. History—New 9-6-93, Formerly 59B-7.018, Amended 6-29-95, 12-28-98, 7-11-01, 2-25-02, 4-18-04, Repealed 1-1-10.

59B-9.022 Penalties for Ambulatory Patient Data Reporting Deficiencies.

(1) For purposes of this rule, a report or other information is “incomplete” when it does not contain all data required by the agency or when it contains inaccurate data and the report is not corrected by the ambulatory center and certified timely pursuant to Rule 59B-9.017, F.A.C. A report or other information is “false” if done or made with the knowledge of the preparer or an administrator that it contains information or data which is not true or accurate.

(2) An ambulatory center which refuses to file, fails to timely file, or files false or incomplete reports or other information required to be filed under the provisions of Section 408.08, F.S., other Florida Law, or a rule adopted thereunder, shall be subject to administrative fines pursuant to Section 408.08(14), F.S.

(3) Reports are deemed delinquent on the first working day following the due date.

(4) Delinquent report notices will be sent via certified mail to the attention of “chief executive officer.”

(5) The penalty period will begin on the first working day following the due date for purposes of penalty assessments.

(6) Any ambulatory center which is delinquent for a reporting deficiency other than submission of a false report shall be subject to a fine of \$100 per day of violation for the first violation, \$350 per day of violation for the second violation, and \$1000 per day of violation for the third or subsequent violations to be fixed, imposed, and collected by the agency. Any ambulatory center which files a false report with the agency or provides false information to the agency shall be subject to a fine of \$1000 per day to be fixed, imposed and collected by the agency.

Specific Authority 408.15(8) FS. Law Implemented 408.006(5), 408.061, 408.08(14) FS. History—New 9-6-93, Formerly 59B-7.022, Amended 6-29-95, Repealed 1-1-10.

59B-9.023 Ambulatory 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. (\$0.15 per one-sided page or \$0.20 per two-sided page.)

(2) Patient-specific records collected by the Agency pursuant to Rules 59B-9.010 through 59B-9.022, F.A.C., are exempt from disclosure pursuant to Section 408.061(8), 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. Record ID Number | Delete or Substitute Sequential Number |
| 2. Patient Social Security Number | Delete or Substitute a Record Linkage Number |
| 3. Patient Birth Date | Substitute Age |
| 4. Patient Zip Code | If less than 500 population for zip code per U.S. census, report a code representing a combination set of zip codes; if out of state, report state, U.S. territory or out of country code. |
| 5. Patient Visit | Substitute Month Indicator (01-12) |

(b) A record linkage number shall be assigned which does not identify an individual patient and cannot reasonably be used to identify individual patients through use of data available through the Agency.

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

(3) Aggregate reports derived from patient-specific records collected pursuant to Rules 59B-9.010 through 59B-9.022, F.A.C., are public records and shall be released as described in subsections (1) and (4) of this rule, provided the aggregate reports do not include record ID number, patient birth date, patient visit date, patient social security number, or patient zip code or provided the aggregate reports contain the combination of five or more records for any data disclosed.

(4) Requests shall be submitted by users sufficiently in advance to permit the staff to respond without disruption of its duties as provided in Section 119.07(1)(b), F.S.

Specific Authority 408.15(8) FS. Law Implemented 119.07, 120.53(2)(a), 408.061 FS. History—New 9-6-93, Formerly 59B-7.023, Amended 6-29-95, Repealed 1-1-10.