



UTAH AMBULATORY SURGERY DATA SUBMISSION MANUAL

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Utah Health Data Committee
Utah Department of Health
Office of Health Care Statistics
288 North 1460 West
PO Box 144004
Salt Lake City, UT 84114-4004



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INTRODUCTION

In accord with Administrative Rule R428-11, beginning January 1, 1997, data on selected ambulatory surgeries are to be collected and submitted to the Office of Health Care Statistics (OHCS). This manual defines which surgeries and what data items concerning those surgeries must be reported. The data are to be submitted for surgeries occurring in hospital outpatient departments, hospital-affiliated ambulatory surgery centers, and freestanding ambulatory surgery centers. At this time, surgical procedures performed as emergency treatment to those ill and injured persons who require immediate **unscheduled** surgical care (e.g., revenue codes 450-459) should **not** be reported to OHCS.

Section 1 of this manual provides an overview of the ambulatory database construction process and identifies the time lines mandated for each step of the process. Section 2 describes each data item to be collected. The information in Section 2 identifies the Uniform Billing form (UB-04) fields and Health Care Financing Administration form (HCFA-1500) items to be collected, how the items are coded, and the edits OHCS will perform on each item. Section 3 specifies the record layout. Section 4 describes the acceptable modes of data submission.

1. The following Current Procedural Terminology (CPT-4) surgical procedure codes are to be reported:

**TYPES OF SURGICAL SERVICE TO BE SUBMITTED
IF PERFORMED IN OPERATING OR PROCEDURE ROOM**

<u>DESCRIPTION</u>	<u>CPT- 4 CODES</u>
Mastectomy	19120-19220
Musculoskeletal	20000-29909
Respiratory	30000-32999
Cardiovascular*	33010-37799
Lymphatic/Hematic	38100-38999
Diaphragm	39501-39599
Digestive System*	40490-49999
Urinary	50010-53899
Male Genital	54000-55899
Female Genital	56405-58999
Endocrine/Nervous	60000-64999
Eye	65091-68899
Ear	69000-69979
Nose, Mouth, Pharynx	<i>CPT Codes in Musculoskeletal & Respiratory</i>
Heart Catheterization	93501-93660

*Starting with 2005 data, the Blood Draw related CPT-4 codes 36000, 36415 and 36600 were removed from the inclusion criteria and are not considered Cardiovascular procedures. In addition, the temporary HCPCs Level II Colorectal cancer screening colonoscopy codes G0104, G0105, G0106, G0120 and G0121 were added to the list for the Digestive System procedures and are retained in the database if reported.

2. These surgeries are to be reported whether or not they were the principal procedure.
3. Any other procedures performed at the same time as the reportable surgeries should also be included.

THIS MANUAL IS EFFECTIVE FOR AMBULATORY SURGERIES BEGINNING OCTOBER 1, 2015.

Effective date: October 1, 2015

Any comments or questions may be addressed to:

OFFICE OF HEALTH CARE STATISTICS
288 North 1460 West
PO Box 144004
Salt Lake City, UT 84114-4004
(801) 538-7048

SECTION 1 OVERVIEW AND SUBMISSION SCHEDULE

This section describes each step involved in constructing the statewide ambulatory surgery database, including data collection, editing, correction, and verification. Data are to be submitted quarterly (see Table 1 below).

ONGOING DATA COLLECTION AND VERIFICATION

OHCS has a statutory mandate to collect billing system-based data on selected ambulatory surgeries (Administrative Rule R428-11).

DATA SUBMISSION

The data submitted are based on surgeries occurring in a calendar quarter. The data submission schedule is as follows:

**Table 1
Hospital and Ambulatory Surgical Facility
Data Submittal Schedule**

<u>If Patient's Date of Discharge is Between:</u>	<u>Discharge Data Record is Due By:</u>
January 1, through March 31	May 15
April 1, through June 30	August 15
July 1 through September 30	November 15
October 1 through December 31	February 15

A record should be submitted for each surgical case, not for each procedure or each bill generated. Only selected items or aggregations of items from the billing system are to be submitted (as specified in Section 2, Data Elements and Edits).

All data should be submitted on computer media. Section 3, Record Layout, specifies the record layout and characteristics required for data submitted on computer media.

Data submissions must be accompanied by a Transmittal Form. OHCS will supply facilities with the necessary transmittal form when requested. Facilities can submit their own transmittal form. The transmittal form must include the number of records in the file, the count of patients, the block size (where applicable), and the record length (see Section 4).

EDITS AND ERROR CORRECTIONS

OHCS will edit the data elements submitted on each individual patient record. The edits will identify erroneous or questionable items that require correction or verification by facilities. These edits generally consist of checking for missing items, invalid codes, or items that are inconsistent with other items on the same record. A list of errors or questionable data items discovered by the individual record level edits will be provided to facilities. This list will also serve as the means for returning data corrections or verifications to OHCS.

In accordance with R428-2-6, each facility will have 10 business days after the receipt of this information to return corrections or verifications to OHCS. OHCS encourages facilities to edit their data prior to submission in order to reduce the magnitude of the correction and/or verification activities during this ten day period. In order to make sure data are corrected before reports are generated, facilities are encouraged to make the corrections and submit them in time for receipt by OHCS before the end of the ten day period.

FINAL REVIEW OF DATA BY FACILITIES

OHCS will correct data based on a facility's response to the edits; construct a statistical profile of the facility's

quarterly data; and send the profile to each facility CEO and designated contact person for their review.

In accordance with R428-2-8(3), each facility has 15 business days after receipt to review its facility profile and to return corrections of any errors that may be uncovered by this review. If the facility fails to respond within the review period, data may be considered suitable for release.

FINAL DATA SET

After each facility has reviewed its profile and corrected any remaining errors, OHCS will correct the data file and prepare the data for release. OHCS will create a number of calculated or derived data items such as patient age, county, etc. The data will be released for general use within the guidelines provided by the administrative rules governing OHCS operations.

SECTION 2 DATA ELEMENTS AND EDITS

ELEMENT NO. 1: FACILITY IDENTIFICATION NUMBER

Description: A number that uniquely identifies the facility. The identifier used is the Federal Tax Number or the Federal Tax Number plus the Federal Tax Sub-ID Number. The use of the second component is a facility option. (*UB-04 Item Number 5; HCFA-1500 Item Number 25*).

General Instructions: This field is left justified with a length of 13 - 10 for the Federal Tax Number and 3 for the Federal Tax Sub-ID Number. The tax number is generally of the form "12-1234567." Whether the Sub-ID Number is used is a facility option. Parent corporations that operate more than one facility or at more than one location will need to use a separate Sub-ID Number or three digit text identification for each facility.

Edits: This element must be present and valid.

ELEMENT NO. 2: PATIENT CONTROL NUMBER

Description: The patient's unique number assigned by the facility to facilitate retrieval of individual case records. (*UB-04 Item Number 3A; HCFA-1500 Item Number 26*).

General Instructions: The Patient Control Number may be any length up to a maximum of 17 characters. This element is required if the facility needs it to retrieve billing records or medical reports. The field should be right justified.

Edits: The element must be present for those facilities that indicate they need it to retrieve information for data corrections.

ELEMENT NO. 3: PATIENT MEDICAL RECORD NUMBER

Description: A number that uniquely identifies a patient in a way that allows information to be tracked back to the medical chart. (*UB-04 Item Number 3B; HCFA-1500 Item Number 26*).

General Instructions: This field is right justified with a length of up to 17 characters.

Edits: This element must be present.

ELEMENT NO. 4: PATIENT SOCIAL SECURITY NUMBER

Description: The social security number of the patient receiving care. (HCFA-1500 Box 1A) (UHIN Standard #2). Insured's ID Number. (UB-04 Item Number 60).

General Instructions: This field is to be left justified with spaces to the right to complete the field. The format of the SSN is 123456789 without hyphens. If a patient does not have a social security number, use the following codes:

200 for a patient who has no SSN,
300 for a patient who chooses not to provide his/her SSN.

Edits: The field is edited for a valid entry.

ELEMENT NO. 5: PATIENT ZIP CODE

Description: The zip code of the patient's residence as given on the billing form. (UB-04 Item Number 9E; HCFA-1500 Item Number 5).

General Instructions:

1. This element has a field length of five.
2. Residence zip code must be recorded for each patient.
3. In the case of nine-digit zip codes, only the first five digits should be reported.
4. For persons giving a residence outside the United States, the field should be zero filled.
5. For unknown zip codes(e.g., homeless patients) the field should be left blank.

Edits:

1. A valid zip code must be present, unless it meets criteria #5 above
2. Zip codes in the range of 84001 through 84999 are validated against known Utah zip codes.

ELEMENT NO. 6: PATIENT BIRTH DATE

Description: Identifies the month, day and year of the patient's birth. (UB-04 Item Number 10; HCFA-1500 Item Number 3).

General Instructions:

1. This is an eight-digit code. It has the Form MMDDCCYY (Month, Day, Century, Year).
2. Month is recorded as a two-digit code ranging from 01 through 12.
3. Day of birth is recorded as a two-digit code ranging from 01 through 31.
4. Year and century of birth is recorded as a four-digit code. If only an age is known, estimate the year of birth.
5. Month and Day should be right justified within its two digits. Any unused space to the left should be zero filled. Example: February 7, 1901 would be recorded as 02071901.

- Edits:**
1. Date of birth must be present and valid.
 2. Date of birth cannot be after the procedure date.
 3. The age of the patient is checked for consistency with diagnostic codes. Consistency between age and diagnostic codes is determined by the annotations to the ICD-9-CM or ICD-10-CM codes

ELEMENT NO. 7: PATIENT GENDER

Description: The patient's gender (*UB-04 Item Number 11; HCFA-1500 Item Number 3*).

General Instructions:

1. This is a one-character code. Gender is to be recorded as male, female, or unknown.

2. Patient gender is coded as follows:

<u>Gender</u>	<u>Code</u>
Male	M
Female	F
Unknown	U

3. Whenever the diagnosis or procedure is gender-specific, the gender code must be consistent with the ICD-9-CM codes indicated.

- Edits:**
1. A valid code ('M,' 'F' or 'U') must be present.
 2. The gender of the patient is checked for consistency with diagnosis and procedure codes. Consistency between gender and the indicated codes is determined by the annotations to the ICD-9-CM or ICD-10-CM codes.

ELEMENT NO. 8: ADMISSION DATE

Description: The date the patient was admitted to the facility for outpatient surgery (*UB-04 Item Number 12; HCFA-1500 Item Number 18*).

General Instructions: The admission date is to be entered as six digits as month, day, and year. The format is MMDDYY. The month is recorded as two digits ranging from 01 through 12. The day is recorded as two digits ranging from 01 through 31. The year is recorded as two digits ranging from 00 through 99. Each of the three components (month, day, year) must be right justified within its two digits. Any unused space to the left must be zero filled. For example February 7, 2008 is entered as 020708.

Edits: Admission date must be present and a valid date. The date cannot be before date of birth or be after ending date in "Statement Covers Period" field.

ELEMENT NO. 9: POINT OF ORIGIN FOR ADMISSION OR VISIT

Description: A code indicating the point of origin for admission or visit (*UB-04 Item Number 15*).

General

Instructions: This is a single digit code describing the source from which the patient was referred. Point of Origin for Admission or Visit codes 1 through 9 or A through F are valid. The code structure is as follows:

1 = Physician Referral

Description: The patient was admitted to this facility upon the recommendation of his or her personal physician. (See code 3 if the physician has an HMO affiliation.)

- 2 = Clinic Referral
Description: The patient was admitted to this facility upon recommendation of this facility's clinic physician.
- 3 = HMO Referral
Description: The patient was admitted to this facility upon the recommendation of a health maintenance organization (HMO) physician.
- 4 = Transfer from a Hospital
Description: The patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient.
- 5 = Transfer from a Skilled Nursing Facility
Description: The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was an inpatient.
- 6 = Transfer from Another Health Care Facility
Description: The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or skilled nursing facility. This includes transfers from nursing homes, long term care facilities and skilled nursing facility patients that are at a non-skilled level of care.
- 7 = Emergency Room
Description: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.
- 8 = Court/Law Enforcement
Description: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.
- 9 = Information Not Available
Description: The means by which the patient was admitted to this hospital is not known.
- A = Transfer from a Critical Access Facility
- B = Transfer from another HHA Facility
- C = Readmission to same HHA
- D = Transfer from Hospital Inpatient in Same Facility
- E = Transfer from Ambulatory Surgery Center
- F = Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program

Edits: The code must be present and valid.

ELEMENT NO. 10: PATIENT'S DISCHARGE STATUS

Description: A code indicating patient status as of the statement covers through date. Generally, indicates the arrangement or event ending a patient's stay in the hospital (*UB-04 Item Number 17*).

General Instructions: This is a code with a length of two digits. The patient's status is coded as follows:

- 01 =Discharge to home or self care, routine discharge.
- 02 =Discharge/transferred to another short-term general hospital
- 03 =Discharge/transferred to skilled nursing facility
- 04 =Discharge/transferred to an intermediate care facility
- 05 =Discharged/transferred to a designated cancer center or children's hospital
- 06 =Discharge/transferred to home under care of organized home health service organization
- 07 =Left against medical advice or discontinued care
- 08 =Discharged/transferred to home under care of a home IV provider
- 09 =Unknown
- 20 =Expired
- 21 =Discharged/transferred to Court/Law Enforcement
- 30 =Still patient (will be excluded from the database)
- 40 =Expired at home
- 41 =Expired in a medical facility (e.g., hospital, ASC).
- 42 =Expired - place unknown
- 43 =Discharged/transferred to federal facility
- 50 =Discharged/transferred to hospice - home
- 51 =Discharged/transferred to hospice – medical facility
- 61 =Discharged/transferred within institution to hospital-based Medicare swing bed
- 62 =Discharged/transferred to another rehab facility including distinct part units in hospital
- 63 =Discharged/transferred to a long term care hospital
- 64 =Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 =Discharged/transferred to a psychiatric hospital or psychiatric unit of a hospital
- 66 =Discharged/transferred to a Critical Access Hospital
- 70 =Discharged/transferred/referred to another type of health care institution not defined elsewhere in this code list
- 71 =Discharged/transferred/referred to another institution for outpatient (as per plan of care)
- 72 =Discharged/transferred/referred to this institution for outpatient services (as per plan of care)
- 81 = Discharged to home or self-care with a planned acute care hospital inpatient readmission (valid 10/2013)
- 82 = Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission (valid 10/2013)
- 83 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (valid 10/2013)
- 84 = Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (valid 10/2013)
- 85 = Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (valid 10/2013)
- 86 = Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission (valid 10/2013)
- 87 = Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (valid 10/2013)
- 88 = Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission (valid 10/2013)
- 89 = Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (valid 10/2013)
- 90 = Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission (valid 10/2013)
- 91 = Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission (valid 10/2013)

- 92 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (valid 10/2013)
 - 93 = Discharged/transferred to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (valid 10/2013)
 - 94 = Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (valid 10/2013)
 - 95 = Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission (valid 10/2013)
- Blank =Not Reported

Edits: The patient status code must be present and a valid code as defined.

ELEMENT NO. 11: DISCHARGE DATE

The ending date of procedure/service must be present and recorded in six digit format of month day year (MMDDYY) (*UB-04 Item Number 6; HCFA-1500 Item Number 18*).

ELEMENT NO. 12: DIAGNOSIS VERSION QUALIFIER

Description: Indicator to designate which version of ICD was used to report diagnosis codes.

General Instructions: Should be initially hard coded to 9 for every record prior to ICD-10.

9 Ninth revision of ICD

0 Tenth revision of ICD

Edits: Must be present and valid.

ELEMENT NO. 13: PRINCIPAL DIAGNOSIS CODE

Description: The condition established, after study, to be chiefly responsible for causing the treatment of the patient (*UB-04 Item Number 67; HCFA-1500 Item Number 21-1*).

General Instructions: 1. Enter the appropriate code that describes the principal diagnosis of the patient.
Enter code left justified without decimals. This field is never right filled with zeros.

2. Diagnoses are coded according to the International Classification of Diseases, 9th or 10th Revision, Clinical Modification (ICD-9-CM or ICD-10-CM).

3. In the ICD-9-CM there are three-digit, four-digit, and five-digit codes. **Use of the fourth or fifth digit is not optional.** If they are present in the ICD-9-CM, they must be used or the code will be rejected as invalid.

4. This element has a field length of 7.

Edits: 1. A principal diagnosis must be present and valid.

2. Whenever the principal diagnosis is gender-specific, the patient gender must be consistent with the ICD-9-CM or ICD-10-CM code. Consistency is determined by the annotations to the ICD-9-CM or ICD-10-CM code.

3. Whenever the principal diagnosis is age-specific, the patient age must be consistent with the ICD-9-CM or ICD-10-CM code. Consistency is determined by the annotations to the ICD-9-CM code or ICD-10-CM.

4. These fields are never right-filled with zeros

5. Screening will be conducted for codes that are not usually used as principal diagnoses. This will be determined by the Medicare Code Edits annotations to the ICD-9-CM or ICD-10-CM code. OHCS should be notified of known, valid exceptions to the Medicare Edits so that unnecessary edit listings will not be sent to the facility for review.

ELEMENTS NO. 14-21: OTHER DIAGNOSIS CODES

Description: Other diagnoses must be reported only if the diagnoses contribute to the substantiation of total charges. Up to eight other diagnoses can be reported (*UB-04 Item Numbers 67A through 67H; HCFA-1500 Item Numbers 21-2 through 21-6*).

General Instructions: 1. Enter the appropriate codes that describe the other diagnoses of the patient.
Enter codes left justified and without decimals. These fields are never right filled with zeros.

2. *For the UB-04 form*, in the ICD-9-CM there are three-digit, four-digit, and five-digit codes. **Use of the fourth or fifth digit is not optional.** If they are present in the ICD-9-CM, they must be used or the code will be rejected as invalid.

3. These elements each have a field length of 7.

Edits: 1. If other diagnoses are gender-specific, the patient gender must be consistent with the ICD-9-CM

or ICD-10-CM. Consistency is determined by the annotations to the ICD-9-CM or ICD-10-CM codes.

2. If other diagnoses are age-specific, the patient age must be consistent with the ICD-9-CM. Consistency is determined by the annotations to the ICD-9-CM or ICD-10-CM codes.
3. Other diagnoses must be valid ICD-9-CM or ICD-10-CM codes.

ELEMENT NO. 22: CPT-4 WITH MODIFIERS 1ST OR PRINCIPLE PROCEDURE CODE

Description: The Current Procedural Terminology CPT-4 code or principal procedure code is a procedure that was performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. The principal procedure is usually that procedure most related to the principal diagnosis (*HCFA-1500 Item Number 24D(1)*).

General

Instructions:

1. Enter the appropriate code that describes the principal procedure performed.
Enter codes left justified without decimals. This field is never right filled with zeros. This element has a field length of 9. The CPT-4 code occupies the first 5 digits and modifiers occupy the last 4 digits, depending on the number of modifiers.
2. The HCFA-1500 procedures are coded according to CPT-4. This coding book is revised annually.
3. When more than one procedure is reported, the 1st or principle procedure must be designated. In determining which of several procedures is the principal procedure, the following criteria apply:
 - a. The 1st or principal procedure is one that was performed for definitive treatment rather than for diagnostic or exploratory purposes, or was necessary to take care of a complication.
 - b. The principal procedure is that procedure most related to the principal diagnosis.
4. This data element must be present if other procedures are reported.
5. Whenever the principal procedure is gender-specific, the gender that is coded must be consistent with the CPT-4 code indicated.
6. For the HCFA-1500, CPT-4 codes are five digits in length with up to two modifiers for each CPT-4 code. Each modifier has two digits **with no dashes**.

Edits:

1. The principal procedure code, if gender-specific, must be consistent with the gender of the patient. Gender specific CPT-4 codes (54000-55899, 76870, 76872 for males and 56000-59899, 74710-76949 for females) are checked for consistency.
2. The principal procedure must be a valid CPT-4 code.
3. Starting with 2005, the Blood Draw related CPT-4 codes 36000, 36415 and 36600 were removed from the inclusion criteria and are not considered Cardiovascular procedures. In addition, the temporary HCPCS Level II Colorectal cancer screening colonoscopy codes G0104, G0105, G0106, G0120 and G0121 were added to the list for the Digestive System procedures and are retained in the database if reported.

ELEMENTS NO. 23-27: OTHER CPT-4 PROCEDURE CODES

Description: Additional procedures performed during the principal operative episode which may include diagnostic or exploratory procedures. Up to five other procedures can be reported (*HCFA-1500 Item Number 24D(2) though (6)*).

- General Instructions:**
1. Enter the appropriate code that describes the other procedures performed.
Enter codes left justified without decimals. These fields are never right filled with zeros. These elements have a field length of 9. The CPT-4 code occupies the first 5 digits and modifiers occupy the last 4 digits, depending on the number of modifiers.
 2. If more than one procedure is reported, the 1st procedure cannot be blank.
 3. Whenever the other procedure is gender-specific, the gender that is coded must be consistent with the CPT-4 code indicated.
 4. For the HCFA-1500, CPT-4 codes are five digits in length with up to two modifiers for each CPT-4 code. Each modifier has two digits with **no dashes**.
- Edits:**
1. Other procedure codes, if gender-specific, must be consistent with the gender of the patient. Gender specific CPT-4 codes (54000-55899, 76870, 76872 for males and 56000-59899, 74710-76949 for females) are checked for consistency.
 2. Other procedure codes must be a valid CPT-4 code.

ELEMENT NO. 28: DATE OF CPT-4 1st OR PRINCIPLE PROCEDURE

Description: The principal procedure date is the year, month and day the principal procedure was performed for the corresponding definitive treatment (*HCFA-1500 Item Number 24A(1)*).

- General Instructions:**
1. Principal procedure date is a six-digit code. It has the form MMDDYY (Month, Day, Year).
 2. Month is recorded as a two-digit code ranging from 01 through 12.
 3. Day of procedure is recorded as a two-digit code ranging from 01 through 31.
 4. Year of procedure is recorded as a two-digit code ranging from 00 through 99.
 5. Each of the three components (Month, Day and Year) should be right justified within its two digits. Any unused space to the left should be zero filled. Example: February 7, 1994 would be recorded as 020794.

- Edits:**
1. Procedure date cannot be before birth date.
 2. Procedure date must fall in the three-month range of each data submission quarter.

ELEMENT NO. 29: PROCEDURE CODING METHOD USED

Description: An indicator that identifies the coding method used for procedure coding. If ICD-9 or ICD-10 procedures only, but not CPT-4, are reported the number 9 or 0 should be entered.

- General Instructions:** The default value should be number 4 for CPT-4. If coding method is NOT CPT-4 enter appropriate code from the list:
- 3 = DSM-III-R
 - 4 = CPT-4
 - 5 = HCPCS (HCFA Common Procedure Coding System)
 - 9 = ICD-9-CM
 - 0 = ICD-10-PCS

Edits: This field must be consistent with the coding method used to code procedures.

ELEMENT NO. 30: STATEMENT COVERS PERIOD

- Beginning Date	N	192-197	6
- Through Date	N	198-203	6

Description: The beginning and ending service dates of the patient's care. The ending date is the discharge date (*UB-04 Item Number 6; HCFA-1500 Item Number 18*).

General Instructions: The two dates are to have MMDDYY formats and the through date must be the date of discharge unless the Type of Billing field indicates an interim record. The months are recorded as two digits ranging from 01 through 12. The days are recorded as two digits ranging from 01 through 31. The years are recorded as two digits ranging from 00 through 99. Each of the three components of both dates (month, day, year) must be right justified within its two digits. Any unused space to the left must be zero filled. For example February 7, 2002 through March 1, 2002 is entered as 020702030102.

Edits: These dates must be present and be valid.

ELEMENT NO. 31: TOTAL CHARGES

Description: Enter total charges for services (total of all charges). Right justified. In the form DDDDDDDCC with no decimal. (*UB-04 Item Number 47; HCFA-1500 Item Number 28*).

ELEMENT NO. 32: PRIMARY PAYER

Payer's Identification

Description: Name and, if required by payer, a number identifying the primary payer organization from which the facility might expect some payment for the bill. (*UB-04 Item Number 50A; HCFA-1500 Item Number 11c*).

General Instructions: This field is to contain the complete name of the primary payer organization. The name should be spelled out as completely as space allows. If a name has more than 25 characters use abbreviations that uniquely identify the organization.

Edits: The name must be that of a verifiable organization.

ELEMENT NO. 33: SECONDARY PAYER

Payer's Identification

Description: Name and, if required by payer, a number identifying the secondary payer organization from which the facility might expect some payment for the bill. (*UB-04 Item Number 50B; HCFA-1500 Item Number 9d*).

General Instructions: This field is to contain the complete name of the secondary payer organization, if applicable. The name should be spelled out completely when space allows. If a name has more than 25 characters, use abbreviations that uniquely identify the organization.

Edits: The name must be that of a verifiable organization.

ELEMENT NO. 34: THIRD PAYER

Description: Name and, if required by payer, a number identifying the tertiary payer organization from which the facility might expect some payment for the bill. (*UB-04 Item Number 50C*).

General This field is to contain the complete name of the tertiary payer organization, if applicable.

Instructions: The name should be spelled out completely when space allows. If a name has more than 25 characters, use abbreviations that uniquely identify the organization.

Edits: The name must be that of a verifiable organization

ELEMENT NO. 35: ATTENDING PHYSICIAN ID

Description: The National Provider ID or Utah Medical License Number of the physician who performed the principal procedure listed on the claim. **Only doctors of medicine and doctors of osteopathy are considered physicians.** (*UB-04 Item Number 76; HCFA-1500 Item Number 24j*).

General 1. The National Provider ID or Utah Medical License Number of the physician who

Instructions: performed the principal procedure listed on the claim.

2. Only the license number should be reported, not the name.

3. Prefixes to the license number (such as T, LT, etc.) must be included.

4. Only the license number of physicians should be reported.

5. If primary responsibility for the patient is in the hands of a non-physician care giver, then this field should be blank filled. Examples can include dentist, psychologist, nurse midwife, podiatrist and chiropractor.

6. This element has a field length of 12.

Edits: This element must be present and valid.

ELEMENT NO. 36: OPERATING PHYSICIAN ID

Description: The National Provider ID or Utah Medical License number of the operating physician who performed the principal procedure listed on the claim. **Only doctors of medicine and doctors of osteopathy are considered physicians** (*UB-04 Item Number 77*).

General 1. The National Provider ID or Utah Medical License Number of the operating physician who

Instructions: performed the principal procedure listed on the claim.

2. Only the license number should be reported, not the name.

3. Prefixes to the license number (such as T, LT, etc.) must be included.

4. Only the license number of physicians should be reported.

5. If primary responsibility for the patient is in the hands of a non-physician care giver, then this field should be zero filled. Examples can include dentist, psychologist, nurse midwife, podiatrist and chiropractor.

6. This element has a field length of 12.

Edits: This element must be present and valid.

ELEMENT NO. 37: TYPE OF BILL

Description: This element is indicative of the type of patient (*UB-04 Item Number 4*).

General Instructions: This is a three-digit field and is used to separate inpatient from ambulatory surgery records when both patient types are submitted together. This field should always be coded as "131", "831", "851" or "999" for ambulatory surgeries.

Edits: Only bill types "131", "831", "851" or "999" should appear on ambulatory records.

ELEMENT NO. 38: PATIENT'S REASON FOR VISIT 1

Description The diagnosis describing the patient's stated reason for seeking care (or as stated by the patient's representative). This may be a condition representing patient distress, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor. Report only one diagnosis code describing the patient's primary reason for seeking care.

General Instructions:

This field is to contain the appropriate ICD-9-CM or ICD-10-CM code without a decimal. In the ICD-9-CM code book there are three, four, and five digit codes plus "V" and "E" codes. Use of the fourth, fifth, "V" and "E" is NOT optional, but must be entered when present in the code. For example, a five-digit code is entered as "12345", a "V" code entered as "V270". All entries are to be left justified with spaces to the right to complete the field length.

Edits: If patient's reason for visit is present they must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.

ELEMENT NO. 39: PATIENT'S REASON FOR VISIT 2

Description The diagnosis describing the patient's stated reason for seeking care (or as stated by the patient's representative). This may be a condition representing patient distress, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor. Report only one diagnosis code describing the patient's primary reason for seeking care.

General Instructions:

This field is to contain the appropriate ICD-9-CM or ICD-10-CM code without a decimal. In the ICD-9-CM code book there are three, four, and five digit codes plus "V" and "E" codes. Use of the fourth, fifth, "V" and "E" is NOT optional, but must be entered when present in the code. For example, a five-digit code is entered as "12345", a "V" code entered as "V270". All entries are to be left justified with spaces to the right to complete the field length.

Edits: If patient's reason for visit is present they must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.

ELEMENT NO. 40: PATIENT'S REASON FOR VISIT 3

Description The diagnosis describing the patient's stated reason for seeking care (or as stated by the patient's representative). This may be a condition representing patient distress, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor. Report only one diagnosis code describing the patient's primary reason for seeking care.

General Instructions:

This field is to contain the appropriate ICD-9-CM or ICD-10-CM code without a decimal. In the ICD-9-CM code book there are three, four, and five digit codes plus "V" and "E" codes. Use of the fourth, fifth, "V" and "E" is NOT optional, but must be entered when present in the code. For example, a five-digit code is entered as "12345", a "V" code entered as "V270". All entries are to be left justified

with spaces to the right to complete the field length.

Edits:

If patient's reason for visit is present they must be valid. When the diagnosis is sex or age dependent, the age and sex must be consistent with the code entered.

**SECTION 3
AMBULATORY SURGERY RECORD LAYOUT**

Element Number	UB-04 Form #	HCFA 1500#	Position	Length	Description/Comments	Right or Left Justified
1	5	25			Facility Identification #	Left
			01-10	10	Federal Tax ID #	
			11-13	3	Federal Tax Sub-ID #	
2	3A	26	14-30	17	Patient Control Number (Optional)	Right
3	3B	26	31-47	17	Patient Medical Record Number	Right
4	60	1A	48-56	9	Patient Social Security Number	Left
5	9E	5	57-61	5	Patient Zip Code	Right
6	10	3	62-69	8	Patient Birth Date (date form MMDDCCYY) (Zero fill MM & DD. Valid date.)	Right
7	11	3	70	1	Patient Gender (values 'M' or 'F')	N/A
8	12	18	71-76	6	Admission Date (date form MMDDYY)	Right
9	15		77	1	Point of Origin for Admission or Visit (Values '1' thru '9', 'A' thru 'F' - See Section 2 for code definition)	Right
10	17		78-79	2	Patient's Discharge Status	Right
11	6	18	80-85	6	Discharge Date (date form MMDDYY)	Right
12			86	1	Diagnosis Version Qualifier	Left
13	67	21(1)	87-93	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	Left
14	67A	21(2)	94-100	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	
15	67B	21(3)	101-107	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	
16	67C	21(4)	108-114	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	
17	67D	21(5)	115-121	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	
18	67E	21(6)	122-128	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	
19	67F	21(7)	129-135	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	
20	67G	21(8)	136-142	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	
21	67H	21(9)	143-149	7	Principal Diagnosis Code ICD-9-CM or ICD-10-CM code	
22		24D(1)	150-158	9	CPT-4 With Modifiers 1 st or Principle Procedure Code	Left
23		24D(2)	159-167	9	Other CPT-4 Procedure Codes	Left
24		24D(3)	168-176	9	Other CPT-4 Procedure Codes	Left
25		24D(4)	177-185	9	Other CPT-4 Procedure Codes	Left
26		24D(5)	186-194	9	Other CPT-4 Procedure Codes	Left
27		24D(6)	195-203	9	Other CPT-4 Procedure Codes	Left
28		24A(1)	204-209	6	Date of CPT-4 or Principal Procedure (Date form MMDDYY. Zero fill MM & DD) (Valid Date)	Right

29			210	1	Procedure Coding Method Used (See Section 2 for codes)	N/A
30	6	18			<u>Statement covers period:</u>	
			211-216	6	Beginning date (MMDDYY)	Right
			217-222	6	Through date (MMDDYY)	Right
31	47	28	223-231	9	Total Charges (In the form DDDDDDDCC With no decimal point) D = Dollars / C = Cents	Right
32	50A	11c	232-256	25	Primary Payer	Left
33	50B	9d	257-281	25	Secondary Payer	Left
34	50C		282-306	25	Tertiary Payer	Left
35	76	24j	307-318	12	Attending Physician ID (Valid Physician ID)	
36	77		319-330	12	Operating Physician ID (Valid Physician ID)	
37	4		331-333	3	Type of Bill	
38			334-340	7	Patient's Reason for Visit 1	Left
39			341-347	7	Patient's Reason for Visit 2	Left
40			348-354	7	Patient's Reason for Visit 3	Left

SECTION 4 ACCEPTABLE MODES OF DATA SUBMISSION

A. Formats:

Each hospital and ambulatory surgical facility shall submit the ambulatory surgery on encrypted electronic media (i.e. CD or DVD) or send them electronically through the Utah Health Information Network or another compatible electronic data interchange network or other secure upload or secure email method. Example of encryption programs include 7-zip, gpg4win, or PGP. Data transfers not in compliance with these specifications will be rejected unless prior approval is obtained.