Florida Center for Health Information and Policy Analysis
Databases

1. **Ambulatory Surgery Data** – Detail patient data is available beginning 1997 which includes freestanding ambulatory surgical centers, hospitals with outpatient services, cardiac catheterization centers and lithotripsy centers. Radiation therapy centers reported data from 1997 through 2003.

2. **Emergency Department Data** – includes hospitals with emergency room department data. Data collection began with calendar year 2005.

3. **Hospital Inpatient Data –** Detail patient data is available beginning 1988 which includes short-term acute hospitals and long-term acute care hospitals.

Hospitals with separate premises from 1988 through 1996 reported data under the main hospital. Beginning 1997, short-term acute care hospital's premises began reporting separately within the hospital patient dataset.

Aggregated data for the short-term acute care psychiatric hospitals were reported from 1987 through 1996. Effective with calendar year 1997, detail patient data for short-term acute care psychiatric hospitals were collected and included in this dataset.

Aggregated data for the long-term psychiatric hospitals were reported from 1987 through 2005.The collection of detail patient data for the long-term psychiatric hospitals began calendar year 2006.

4. **Comprehensive Rehabilitation (Comp Rehab) Hospitals** – Detail patient data is available beginning 3rd quarter 1993 which includes data for the freestanding comprehensive rehabilitation hospitals. Comp rehab data are not collected from the short-term and long-term acute care hospitals.

Key Differences for Hospital Inpatient Data File (includes Psychiatric Hospitals)
Effective January 2006

1. Type of admission – The number "5" is now "Trauma Center". This number was previously designated as "Other".

2. Source of Admission- The number **"**09" is now "Information Not Available". This was previously designated as "Other".

3. Discharge Status – "62", "63", and "65" are acceptable reportable codes.
62 – Discharged to an inpatient rehabilitation facility/unit
63 – Discharged to a Medicare certified long term care hospital
65 – Discharged to a psychiatric hospital / unit

4. Principal Payer- Payer "B", Medicare HMO or Medicare PPO, was defined as Medicare HMO prior to first quarter 2006.

5. Principal Diagnosis Code - The diagnosis codes now include decimal points between the third and fourth digit. Prior to first quarter 2006, the decimal points were not included.

6. Other Diagnosis Codes - The number of fields for other diagnosis codes were expanded from four to nine beginning with first quarter 1992 data. Effective first quarter 2006, the number of fields for other diagnosis codes expanded from nine to thirty fields. Decimal points are now included between the third and fourth digit of the diagnosis codes. Prior to first quarter 2006, secondary diagnosis codes did not include decimal points.

7. Present on Admission Indicators - A required reported field beginning second quarter 2007.

- **Principal Diagnosis Present on Admission Indicator** – Present on Admission for principal diagnosis is available beginning 1st quarter 2007.

- **External Cause of Injury Present Admission Indicator**- Present on Admission for external cause of injury is available beginning 1st quarter 2007.

- **Other Diagnosis Present on Admission Indicator** - Present on Admission (POA) for secondary diagnoses is available beginning with first quarter 2006 data however required reporting began second quarter 2007.

8. Principal Procedure Code - These procedure codes now include the decimal point between the second and third digit. Prior to first quarter 2006, the decimal points were not included.

9. Other Procedure Codes - The number of fields for secondary procedure codes was expanded from two to nine beginning with first quarter 1992 data. Effective first quarter 2006, the number of fields for 'Other Procedure Codes' expanded from nine to thirty fields. The codes now include decimal points. Prior to first quarter 2006, the decimal points were not included between the second and third digit.

10. Days to Procedure – The number of fields for 'Days to Procedure' expanded from one to thirty-one fields beginning first quarter of 2006. Previously, the field was coded with 999 to indicate when no procedure is performed or unable to compute days to procedure. Currently, a blank (null value) indicates when no procedure is performed or when unable to compute days.

11. Other Operating or Performing Physician ID – **New field**.

12. Admitting Diagnosis Code – New field.

13. External Cause of Injury Codes - New fields - Occurs up to 3 times and includes decimal points.

14. Emergency Department Hour of Arrival - New field.

15. Nursery Charges – As of January 2006, this field no longer contains Level III Nursery Charges (Revenue Code 173). This field includes Revenue Codes 170 through 172 and Codes 174 through 179

16. Level III Nursery Charges - New field - Level III Nursery Charge data is reported separately beginning with first quarter 2006. This field includes Revenue Code 173.

17. Pharmacy Charges - This data field now includes revenue codes 250 through 259 and codes 630 through 639. Previously, this category included Codes 250 through 259.

18. Medical and Surgical Supply Charges - This data field now includes revenue codes 270 through 279 and codes 620 through 629. Previously, this category included Codes 270 through 279.

19. Laboratory Charges - This data field now includes revenue codes 300 through 319. Previously, Codes 300 through 309 and Codes 310 through 319 were reported separately.

20. Radiology or Other Imaging Charges - This data field now includes revenue codes 320 through 359 and codes 400 through 409 and codes 610 through 619. Previously, Codes 320 through 329, Codes 330 through 339, Codes 340 through 349, Codes 350 through 359, and Codes 610 through 619 were reported separately. Codes 400 through 409 were included in Other Charges.

21. Respiratory Services or Pulmonary - This data field now includes revenue codes 410 through 419 and codes 460 through 469. Previously, Codes 410 through 419 were reported separately and Codes 460 through 469 were included in Other Charges.

22. Physical and Occupational Therapy - This data field now includes revenue codes 420 through 449. Previously, Codes 420 through 439 were reported separately and Codes 440 through 449 were included in Other Charges.

23. Trauma Response Charges - New field - This data field includes revenue codes 680 through 689. Previously, Codes 680 through 689 were included in Other Charges.

24. Treatment or Observation Room Charges- New field - This data field includes revenue codes 760 through 769. Previously, Codes 760 through 769 were included in Other Charges.

25. Behavioral Health Charges - New field - This data field includes revenue codes 900 through 919 and codes 1000 through 1009. Previously, Codes 900 through 919 and Codes 1000 through 1009 were included in Other Charges.

26. Pro Code - New field - This two digit number indicates the facility's type of license for patient services.

27. Mod Code - New field - This two digit number indicates the specialty type of facility.

28. Facility County – New field - This number indicates the facility's location by county.

29. Facility Region – New field - This number indicates the facility's location by AHCA district, as defined in 408.032 (5), Florida Statutes.

30. Zip Code - Zip code data are no longer masked for inpatient data. Previously, the zip codes were masked if the patient's residence was outside of Florida or in an area within the state where the population is less than 500 people. The codes were as follows:

00000 – Unknown Zip Codes
00008 – Other States and Territories
00009 – Not a U.S. resident
00011 – Masked Zip Code 32000 to 32499
00012 – Masked Zip Code 32500 to 32999
00013 – Masked Zip Code 33000 to 33499
00014 – Masked Zip Code 33500 to 33999
00015 – Masked Zip Code 34000 to 34499
00016 – Masked Zip Code 34500 to 34999
00007 – Homeless (Start 1/02, formerly 22222)

31. Length of Stay – All data are updated with discharges on the same day admitted as a stay of zero (0). Previously, patients discharged on the same day admitted were computed as a stay of one (1) day.

32. Diagnosis Related Group (DRG) – Effective fourth quarter 2007, the Medicare Severity- Diagnosis Related Group (MS-DRG), a refinement of the Diagnosis Related Group (DRG), is reported in the DRG field.
Data for 2007 quarters one through three, as well as, prior reported years are grouped using the applicable Diagnosis Related Group (DRG) version as directed by Centers for Medicare and Medicaid Services.

Key Differences for Ambulatory Data File (includes Emergency Department)
Effective January 2005

1. Type of Service Code - New field - 1 – Ambulatory Service; 2 – Emergency Department

2. Principal Diagnosis Code - These diagnosis codes now include decimal points.

3. Other Diagnosis Codes - the number of fields for 'Other Diagnosis Codes' were collapsed from fourteen (14) to nine (9). The secondary diagnosis codes now include decimal points.

4. Principal CPT or HCPCS Procedure Code - New name – Previously "Primary Procedure Code".

5. Other CPT or HCPCS Procedure Code – The number of fields for 'Other Procedure Codes' were collapsed from fourteen (14) to nine (9). The fourteen secondary procedure fields were reported from 1997 through 2004. Beginning first quarter 2005, the number of secondary procedure fields reported was reduced to nine.

6. Other Physician ID – **New Field**.

7. Patient Reason for Visit - Admitting Diagnosis Code – New Field - Codes include decimal points. Required field if Type of Service Code is "2" (Emergency Department).

8. Principal ICD-9-CM Code – **New Name-** Previously "Principal Procedure Code" – Effective first quarter 2005, the codes include decimal points. From 1997 to 2004, the principal procedure codes were reported without decimal points.

9. Other ICD-9-CM Code - Occurs up to 4 times. Effective first quarter 2005, the codes include decimal points. From 1997 to 2004, the procedure codes were reported without decimal points.

10. External Cause of Injury Codes – **New Field** - external cause of injury data is available in separate fields. Codes reflect decimal point. Occurs up to 3 times.

11. Patient Visit Beginning Date - New Field.

12. Patient Visit Ending Date – **New Field**.

13. Hour of Arrival – New Field - Required field if Type of Service Code is "2" (Emergency Department).

14. Principal Payer Code – New Payer Code: Code P – Unknown, is reported only if payer information is not available, and type of service is "2" (Emergency Department) and patient status is "07" (Left Against Medical Advice or Discontinued Care).

15. Patient Status (Discharge Status) – New Patient Status Codes -additional codes effective first quarter 2005:
50 – Hospice home;
51 – Hospice medical facility;
62 – Inpatient rehabilitation facility/unit

16. Radiology and Other Imaging Charges – **New Field** – Combines "Radiation Oncology Charges", "CT Scan Charges", and "MRI Charges". Previously these charges were separate. Now includes all types of diagnostic and therapeutic radiology services.

17. Emergency Room Charges – New Field.

18. Procode – New Field - This two digit number indicates the facility's type of license for patient services.

19. Facility County – New field - This number indicates the facility's location by county.

20. Facility Region – New field - This number indicates the facility's location by AHCA district, as defined in 408.032 (5), Florida Statutes.

21. Length of Service – New field - Calculates number of days between visit beginning date and visit ending date. Patients that have a Length of Service of zero (0) received services that began and ended on the same day.