CHAPTER 218

RULES AND REGULATIONS GOVERNING

OUTPATIENT HEALTH DATA REPORTING

12VAC5-218-10. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise:

"Board" means the State Board of Health.

"Inpatient hospital" means a hospital providing inpatient care and licensed pursuant to Article 1 (§32.1-123 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia, a hospital licensed pursuant to Chapter 8 (§37.1-179 et seq.) of Title 37.1 of the Code of Virginia, a hospital operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services for the care and treatment of the mentally ill, or a hospital operated by the University of Virginia or Virginia Commonwealth University Health System Authority.

"Nonprofit organization" means a nonprofit, tax-exempt health data organization with the characteristics, expertise and capacity to execute the powers and duties set forth for such entity in Chapter 7.2 (§32.1-276.2 et seq.) of Title 32.1 of the Code of Virginia and with which the Commissioner of Health has entered into a contract as required by the Code of Virginia.

"Outpatient processed, verified data" means data on outpatient records that have been subjected to edits. These edits shall be applied to data elements which are on the UB-92 Billing Form, HCFA 1500 Billing Form or a nationally-adopted successor Billing Form used by reporting entities. The edits shall have been agreed to by the Board and the nonprofit organization. Outpatient records containing invalid UB-92 codes, HCFA 1500 codes, another nationally adopted billing form codes or all blank fields for any of the data elements subjected to edits shall be designated as error records. To be considered processed and verified, a complete filing of outpatient surgical procedures specified by the Board submitted by a reporting entity in aggregate per calendar year quarter and which are subjected to these edits must be free of error at a prescribed rate. The overall error rate shall not exceed 5%. A separate error rate shall be calculated for patient identifier, and it shall not exceed 5%. The error rate shall be calculated on only those fields approved by the Board through the process specified in 12VAC5-218-40.

"Outpatient surgery" means all surgical procedures performed on an outpatient basis in a general hospital, ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to Article 1 (§32.1-123 et seq.) of Chapter 5 of this title or in a physician's office. Outpatient surgery refers only to those surgical procedure groups on which data are collected by the nonprofit organization as a part of a pilot study.

"Physician" means a person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

"Physician's office" means a place (i) owned or operated by a licensed physician or group of physicians practicing in any legal form whatsoever or by a corporation, partnership, limited liability company or other entity that employs or engages physicians, and (ii) designed and equipped solely for the provision of fundamental medical care, whether diagnostic, therapeutic, rehabilitative, preventive or palliative, to ambulatory patients.

“Reporting entity” means every general hospital, ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to Article 1 (§32.1-123 et seq.) of Chapter 5 of this title and every physician performing surgical procedures in his office.

"Surgical procedure group" means at least five procedure groups, identified by the nonprofit organization designated pursuant to § 32.1-276.4 in compliance with regulations adopted by the Board, based on criteria that include, but are not limited to, the frequency with which the procedure is performed, the clinical severity or intensity, and the perception or probability of risk. The nonprofit organization shall form a technical advisory group consisting of members nominated by its Board of Directors' nominating organizations to assist in selecting surgical procedure groups to recommend to the Board for adoption.

"System" means the Virginia Patient Level Data System.

12VAC5-218-20. Statutory Authority

§§32.1-276.3, 32.1-276.6, 32.1-276.8 and 32.1-276.9 of the Code of Virginia.

12VAC5-218-30. Historical Notes

This is a new section added to implement HB-2763 as approved by the General Assembly during its 2001 session.

12VAC5-218-40. Reporting requirements for outpatient data elements.

Every reporting entity performing outpatient surgical procedures shall submit each patient level data element listed below for each patient for which an outpatient surgical procedure is performed and for which the data element is collected on the standard claim form utilized by the reporting entity. Most of these data elements are currently collected from a UB-92 Billing Form or HCFA 1500 Form. In the table below, the column for a field description indicates where the data element is located on the UB-92 and HCFA 1500 forms. An asterisk (*) indicates when the required data element is either not on the UB-92 or the HCFA 1500. The instructions provided under that particular data element should then be followed. If a successor billing form to the UB-92/HCFA 1500 form is adopted nationally, information pertaining to the data elements listed below should be derived from that successor billing form. The nonprofit organization will develop detailed record layouts for use by reporting entities in reporting outpatient

surgical data. This detailed record layout will be based upon the type of base electronic or paper-billing form utilized by the reporting entity. Outpatient surgical procedures reported will be those adopted by the Board of Health as referred by the nonprofit organization. The nonprofit organization may recommend changes to the list of procedures to be reported not more than annually.

Data Element Name	Instructions	UB-92 Form Locator	HCFA 1500 Field Number
Hospital Identifier	Hospitals and ambulatory care centers enter the six-digit Medicare provider number, or when adopted by the Board of health- the National Provider Identifier or other number assigned by the Board. Physicians, leave blank	N/A-see Instructions	N/A see instructions
Operating Physician Identifier	Enter the nationally assigned physician identification number, either the Uniform Physician Identification Number (UPIN), National Provider Identifier (NPI) or it's successor as approved by the Board of Health for the physician identified as the operating physician for the principal procedure reported.	83 A & B	17a but with NPI
Payor Identifier	Enter the Board of Health approved payor designation which will be the nationally assigned PAYERID, it's successor, or English description of the payor	50 A, B, C 50-1 through 50-11 as described in instructions	9d as described in instructions
Employer Identifier	Enter the federally approved EIN, or employer name, whichever is adopted by the Board of Health.	65 A with name/codes noted in instructions	9c with name/codes noted in instructions
Patient Identifier	Enter the nine-digit social security number of the patient. If a social security number has not	Not specified as to patient	Not specified as to patient

	been assigned, leave blank. The nine-digit social security number is not required for patients under four years of age.		
Patient Sex		15	3
Date of Birth	Enter the code in MM/DD/YYYY format.	14 Must be in format specified in instructions	3 Must be in format specified in instructions
Zip Code		13	5
Patient Relationship to insured		59 A, B, C	6
Employment status code		64 A, B, C	8
Status at discharge		22	Use outpatient UB-92 codes
Admission Date	Admission/start of care date	17	24A
Admission Hour	Hour of admission in military time 00-24	18	See instructions
Admission Diagnosis	Code sets- ICD 9 or CPT 4 or their successors to be specified in detailed record layouts.	76	*
Principal Diagnoses	Code sets- ICD 9 or CPT 4 or their successors to be specified in detailed record layouts.	67	21-1
Secondary Diagnoses	Code sets- ICD 9 or CPT 4 or their successors to be specified in detailed record layouts.	68 to 75t	21-2 to 21-4
External Cause of Injury	(E-code). Record all external cause of injury codes in secondary diagnoses position after recording all treated secondary diagnoses.	77	*
Co-morbid condition existing but not treated	Enter the code for any co-morbid conditions existing but not treated. Code sets- ICD 9 or CPT 4 or their successors to be specified in detailed record layouts.	*	*

Procedures	Code sets- ICD 9 or CPT 4 or their successors to be specified in detailed record layouts.	80	24d:1 to 24d:6
Procedure Dates		81	24a:1 to 24a:6
Revenue Center codes	As specified for UB –92 completion, not available for HCFA 1500	42	N/A
Revenue Center Units		46	24g:1 to 24g:6
Revenue Center charges		47	24f:1 to 24f:6
Total Charges		(R.C. Code 001 is for total charges.	28

12VAC5-218-50. Options for filing format.

Reporting entities that perform on an annual basis one hundred or more of the specified outpatient surgical procedures shall submit patient level data in an electronic data format. Reporting entities performing fewer than 100 of the specified outpatient surgical procedures annually that submit patient level data directly to the Board or the nonprofit organization may directly submit it in electronic data format or in hard copy. If hard copy is utilized the reporting entity shall submit, for each outpatient discharged, a copy of the UB-92/HCFA 1500 and an addendum sheet for those data elements not collected on the UB-92/HCFA 1500, or nationally adopted billing form. These reporting entities performing specified outpatient surgical procedures must submit all outpatient patient level data in electronic data format by January 1, 2004.

12VAC5-218-60. Options for submission.

Each reporting entity shall submit the outpatient patient level data to the Board for processing and verification. If data is submitted in this fashion, the Board will transmit it to the nonprofit organization along with any fees submitted by the reporting entity to the Board for the processing and verification of such data.

As an alternative to submitting the outpatient patient level data to the Board, a reporting entity may submit the outpatient patient level data to the office of the nonprofit organization for processing and verification. If this alternative is chosen, the reporting entity reporting the outpatient patient level data shall notify the Board and the nonprofit organization of its intent to follow this procedure.

In lieu of submitting the patient level data to the Board or to the nonprofit organization, a reporting entity may submit already processed, verified data to the nonprofit organization. If a reporting entity chooses this alternative for submission of patient level data, it shall notify the Board and the nonprofit organization of its intent to utilize this procedure.

If a reporting entity decides to change the option it has chosen, it shall notify the Board of its decision 30 days prior to the due date for the next submission of patient level data.

12VAC5-218-70. Contact person.

Each reporting entity shall notify in writing the Board and the nonprofit organization of the name, address, telephone number, email (where available) and fax number (where available) of a contact person. If the contact person changes, the Board and the nonprofit organization shall be notified in writing as soon as possible of the name of the new person who shall be the contact person for that reporting entity.

12VAC5-218-80. Frequency of submission.

A. Reporting entities shall submit the data required by 12VAC5-218-40 at least on a calendar year quarterly basis.

B. If the data is submitted to the Board or to the nonprofit organization for processing and verification, it shall be received at the office of the Board or the office of the nonprofit organization within 45 days after the end of each calendar year quarter.

C. If a reporting entity chooses to submit processed, verified data directly to the nonprofit organization, it shall be received at the office of the nonprofit organization within 120 days after the end of each calendar year quarter.

12VAC5-218-90. Establishment of annual fee.

There shall be no fees levied for outpatient surgical data submitted for the first four calendar quarters of data submission.