Alberta
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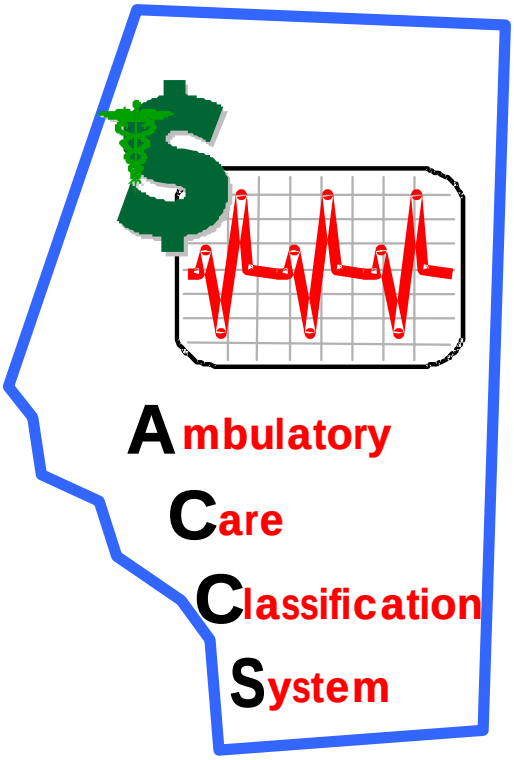
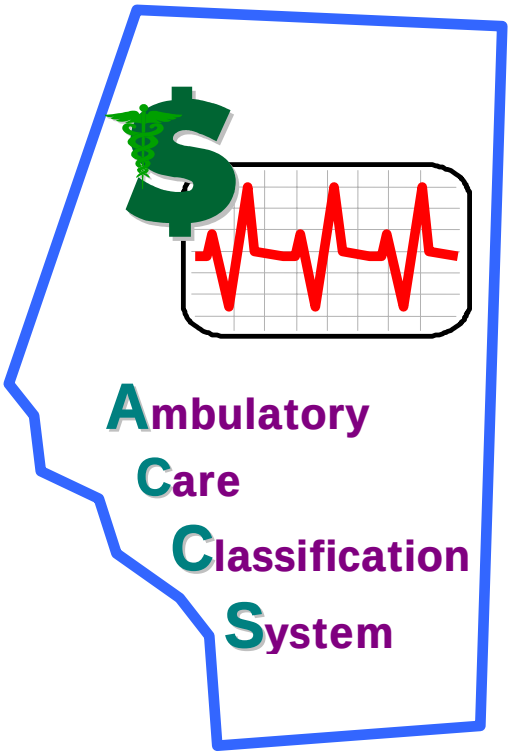


Alberta Ambulatory Care Reporting Manual

Effective April 2005

Alberta Ambulatory Care Reporting Manual



For additional copies of this manual, contact:

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19th Floor, 10025 Jasper Avenue
Edmonton, Alberta, Canada T5J 2N3
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Effective April 2005

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Alberta Ambulatory Care Reporting Manual

Introduction

Background

The Ambulatory Care Classification System (ACCS) was developed in Alberta through the Ambulatory Care Classification Project which was in existence from April 1994 – September 1995. The intent of the project was to create a fully integrated ambulatory care patient classification system for acute care facilities. The project began with a review of existing groupers and used these in combination with Alberta data to develop ACCS. In addition to advice and input from ambulatory care clinical experts, Alberta data from several hospitals were used in the grouper development. Data have been collected by the regions for ACCS and submitted to Alberta Health and Wellness since 1997.

The data collected for the ACCS grouper are used to classify ambulatory service recipients into clinical groups with similar resource needs and clinical profiles. The collection of data for the ACCS grouper does not replace MIS (Management Information System) reporting of workload statistics and costs nor does it replace data collection of additional elements required for purposes of management, service recipient satisfaction results or quality assurance.

The major reason underlying ACCS grouper/Minimum Data Set development and subsequent data collection is to provide useful information for utilization analyses and management, for both hospitals and the provincial government. Consistent and accurate collection of these data elements is integral to the ACCS grouper, which is used to develop the Ambulatory Care relative value index (RVI) and subsequently resource allocation through the population based funding formula.

Purpose of the Manual

This manual is intended to outline reporting requirements for Regional Health Authorities (RHAs) collecting the Alberta Ambulatory Care Minimum Data Set, and should be used at information sessions covering the data elements. This manual should be referred to throughout the development, implementation, and maintenance phases of collecting the data elements. The defined set of common data elements collected by the RHAs is described in the Data Elements section where both mandatory and optional elements are outlined.

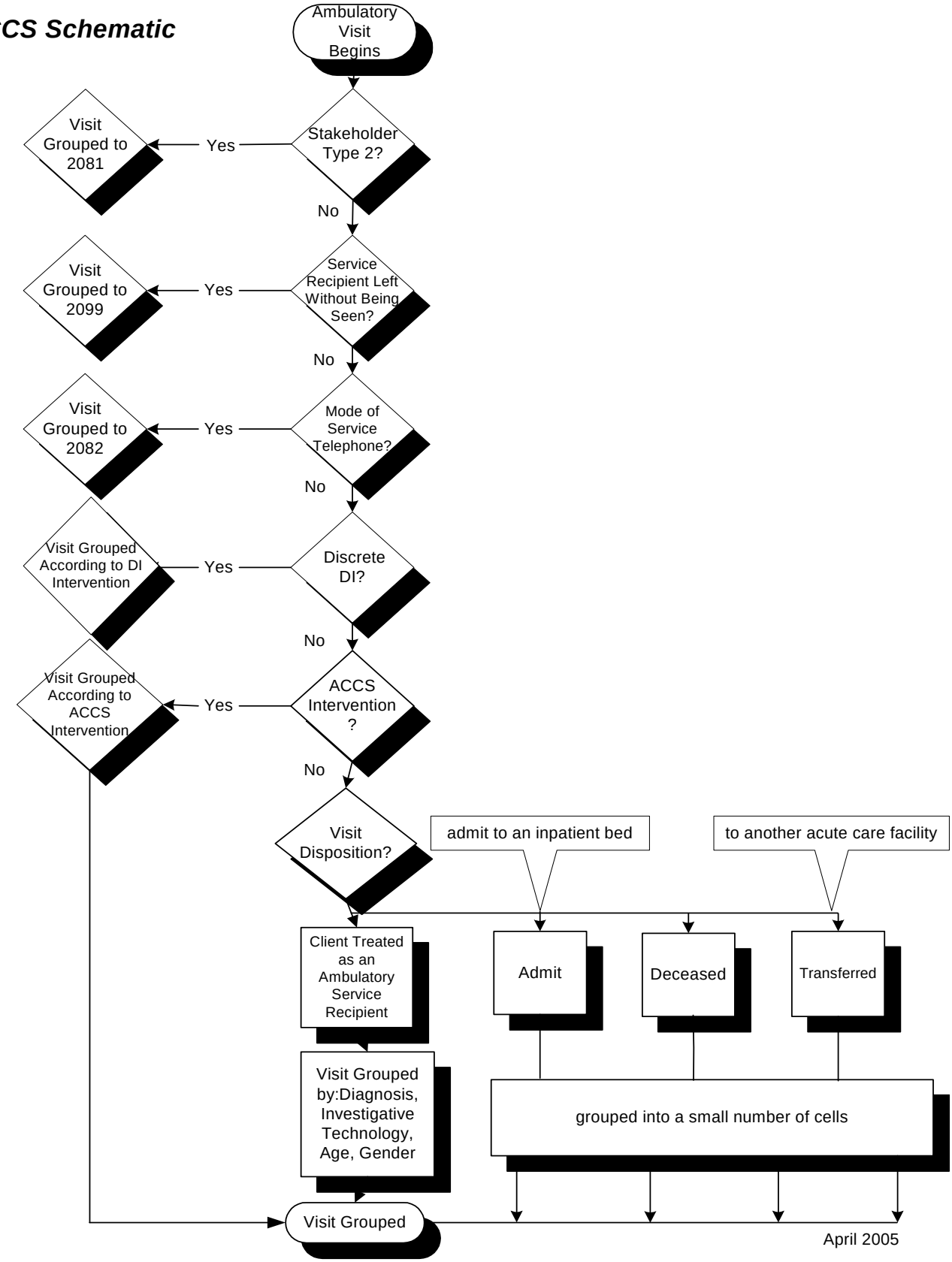
In addition to the data elements, a fairly extensive listing of coding standards and reporting examples are provided. As well, Sections 1 – 8 outline:

- List of Major Clinical Categories and Names
- List of ACCS Grouper Cells and Names
- List of CCI Codes with Alberta-developed Attributes
- List of ACCS Investigative Technologies
- ACCS/ CCI Intervention Codes
- MIS Primary Accounts Valid for ACCS Reporting

- Institution Number List and the
- ACCS Groups: Flowcharts, Diagnoses and Interventions

For clarification or further information on any of the reporting requirements, contact Alberta Health & Wellness at (780) 427-7040

ACCS Schematic



Data Set

The elements included in the data set were chosen to provide maximum flexibility. Three kinds of data are required to classify ambulatory care service recipients and evaluate ambulatory care programs:

1. Data required to classify service recipients according to clinical homogeneity (ACCS grouper). All health regions will submit these data elements in order to have their visits grouped. Examples of these data elements include age, gender intervention/diagnosis code and service recipient disposition.

2. Data needed to develop predicted resource needs. A relative value index (RVI) has been developed for funding and other resource allocation decisions. These RVIs are based on the patient specific costs in ambulatory care programs collected by some costing regions participating in the Alberta Costing partnership.

   These costing data include provider type, time taken for service recipient care, resources consumed in terms of diagnostic/supplies/drugs, and other costs in providing care that affect resource needs.

3. The developed RVIs are provincial in nature and applicable to all Regional Health Authorities.

To enable the Ambulatory Care activity data to be useful in population based funding, additional information regarding patient demographics, service date and provider location are also required to be collected.

ALBERTA AMBULATORY CARE MINIMUM DATA SET ELEMENTS

revised: April 2005

MANDATORY ACCS GROUPER DATA ELEMENTS	REQUIRED FOR GROUPING	COMMENTS
Administrative		
1. Institution Number		• Necessary for submission of data
2. Submission Period		
3. Submission Number		
4. Submission Type		
Demographic		
5. Unique Lifetime Identifier (ULI)		• A unique and permanent number assigned to all persons who receive health services in Alberta
6. Personal Health Number		• Unique health care coverage number assigned by the provincial government of residence
7. Responsibility for Payment		• Used to exclude federal government, WCB**,** etc.
8. Postal Code		• Used at regional level • Track service flow between regions
9. Birth Date	✓	• YYYYMMDD • Used to calculate age in conjunction with visit date and also for per capita calculations
10. Gender	✓	• Male • Female • Undifferentiated • Other
11. Institution From		• Indicates service recipients referred in from another health care facility; also tracks service flows between regions
12. Admit Via Ambulance		• Indicates if service recipient brought to service delivery site by ambulance
13. Institution To		• Indicates service recipient referred out to another health care facility for further treatment
Clinical		
14. Service Visit Date	✓	• YYYYMMDD • Used to calculate age for service recipient classification
15. Doctor Number		• The facility assigned physician number of the doctor responsible for care/treatment of the service recipient
16. Provider Type		• Mandatory for mental health service, emergency, and day surgery recipients; optional for all others

MANDATORY ACCS GROUPER DATA ELEMENTS	REQUIRED FOR GROUPING	COMMENTS
17. MIS Primary Code		• Identifies the ambulatory care services provided
18. Mode of Service	✓	• Indicates service is provided face to face, off site, in group therapy, etc.
19. Disposition	✓	• Identifies service recipient's type of separation
20. Diagnosis Prefix		• Blank or Q for questionable or query diagnosis
21. Main Ambulatory Care Diagnosis	✓	• Diagnosis condition, problem or intervention that is the main reason for the visit • For multiple diagnosis, main is the one responsible for the greatest use of resources
22. Secondary Diagnoses	✓	• Conditions or problems influencing a service recipient's treatment – maximum of 9 occurrences
23. Anaesthetic Type	✓	• Indicates general, spinal, epidural, etc.
24. Main Intervention	✓	• Identifies intervention performed considered to be most clinically significant
25. Other Interventions	✓	• Maximum of 9 occurrences
26. Intervention Attributes	✓	• Used to further specify an intervention
27. Out of Hospital Indicator	✓	• Indicates interventions performed during the current visit but carried out at another site
28. Number of Previous Term Deliveries for Therapeutic Abortion Cases		• Number of previous full term deliveries
29. Number of Previous Pre-Term Deliveries for Therapeutic Abortion Cases		• Number of previous pre-term deliveries
30. Number of Previous Spontaneous Abortions for Therapeutic Abortion Cases		• Number of previous spontaneous abortions
31. Number of Previous Therapeutic Abortions for Therapeutic Abortion Cases		• Number of previous legal therapeutic abortions
32. Gestational Age for Therapeutic Abortion Cases		• The gestational age, reported in weeks

MANDATORY ACCS GROUPER DATA ELEMENTS	REQUIRED FOR GROUPING	COMMENTS
33. Date of Last Menses for Therapeutic Abortion Cases		• Date of last menses

OPTIONAL ACCS GROUPER DATA ELEMENTS	COMMENTS
34. Registration Time	• HHMM • Time service recipient registered at facility • Mandatory to report for emergency and day surgery visits
35. Disposition Time	• HHMM • Time service provider discharges client • Mandatory to report for emergency and day surgery visits
36. Date Visit Completed	• YYYYMMDD
37. Triage Level	• Applicable only to service recipients seen in Emergency Department • As of April 1st, 2004 triage level is mandatory to report for urban hospitals. As of April 1st 2005 triage level is mandatory to report for regional hospitals.
38. Residence Name	• First seven letters of the name of the place of residence of the service recipient
39. Doctor Type	• Describes role of physician associated with service recipient
40. Doctor Service	• Reflects level of training or specialty of physician • Not appropriate to report a doctor service without reporting physician number
41. Chart Number	• Aids in service recipient health record identification
42. Referral Source	• Identifies the type of person or agency making the referral
43. Referred-to Agency	• Identifies the type of person or agency to which a service recipient is referred to
44. Stakeholder Type	• Identifies whether the stakeholder is a person or an organization
45. Coder Number	• The number identifying the person responsible for completing the record reported

ADDITIONAL FIELDS ON FILE LAYOUT (NON-ABSTRACTED DATA ELEMENTS)	COMMENTS
46. Record Type	• Identifies type of record within data submission
47. Fiscal Year	• Represents the year the fiscal year concludes in
48. Site Code	• Identifies the exact site where services are provided
49. Service Event Number	• Used for internal facility identification of services event
50. Encounter Number	• Facilitates internal tracking of service event episode

Progress Report

ACCS data collection has increased from 1998-99 to 2002-2003. The majority of RHAs have indicated they are collecting and submitting close to 100% of their ambulatory care activity to Alberta Health and Wellness. The following table lists the changes in data submissions on a regional basis from 1998-99 to 2002-03.

ACCS Data - Number of Records Submitted by Region

Region*	1999-00 Records Submitted	2000-01 Records Submitted	2001-02 Records Submitted	2002-03 Records Submitted	2003-04 Records Submitted	Change Over 2002-03	% Change 2002-03
Chinook	289,771	321,551	338,729	320,425	315,801	-4,624	-1.4%
Palliser	185,542	220,846	212,070	185,067	196,670	11,603	6.3%
Calgary	826,122	1,378,741	1,538,671	1,696,926	2,171,325	474,399	28.0%
David Thompson	400,026	512,034	526,795	535,854	550,192	14,338	2.7%
East Central	159,737	207,118	209,552	208,483	216,263	7,780	3.7%
Capital	1,654,615	2,022,732	2,178,960	2,385,511	2,460,054	74,543	3.1%
Aspen	295,029	419,991	413,339	419,246	406,810	-12,436	-3.0%
Peace	317,143	342,279	350,137	349,963	358,516	8,553	2.4%
Northern Lights	86,083	112,698	135,241	127,438	137,113	9,675	7.6%
Total Annual Records	**4,214,068**	**5,537,990**	**5,903,494**	**6,228,913**	**6,812,744**	**583,831**	**9.4%**
% Change		31.4%	6.6%	5.5%	9.4%		
Active Population	**2,956,072**	**3,006,638**	**3,071,586**	**3,123,744**	**3,164,500**	**40,756**	**1.3%**
% Change		1.7%	2.2%	1.7%	1.3%		

*****Regional boundaries as of December 1st 2003

ACCS Reporting Contacts

Alberta Health & Wellness is fortunate to have two advisory groups to provide input into reporting and coding issues. These advisory groups include representatives from all Regional Health Authorities and should be considered as the first point of contact when reporting issues or questions arise. The two groups are:

- Provincial Ambulatory Care Advisory Group (PACAG)
- Health Record Advisory Committee (HRAC)

Please Note: An updated list of the committees' membership and contact information will be maintained and can be viewed with the ACCS Manual 2005 files on the Alberta Health and Wellness website at:

http://www.health.gov.ab.ca/resources/publications/ACCS_manual_05/index.htm

Please consult these representatives on any issues that may arise. If the issue cannot be resolved at the Regional level, these representatives are encouraged to bring the concern to the next meeting of the advisory group of which they are a member or contact the appropriate individual below:

Policy Issues	Habib Fatoo	780-427-8018
Technical Issues or Clarification	Shirley Groenen	780-427-8025
	Kasia Kunikiewicz/ Dennis Schrieber	780-422-5083/ 780-427-7132
Website Issues	Brent Hudyma	780-415-1101

Tab:

Visit Examples & Coding Standards

Visit Definitions

Ambulatory Care Visit Definition (See Examples 1-12)
A visit is defined as an attendance at an ambulatory care service area during which service activities are provided to the service recipient and/or significant other(s) on behalf of the service recipient.

Valid codes for clinical data reporting are 713 and some 714 and 715 codes in the Alberta MIS - Primary Chart of Accounts, (see Section 5). There are two exceptions to this standard:

7112060 Employee Health (valid code for reporting ambulatory care activity)
7135099 Clinical Administration (invalid code for reporting ambulatory care activity)

Mental Health Service Recipient Definition (See Examples 13-15)
Mental Health Service Recipient (for the purposes of reporting mental health intervention information): is an individual who seeks the services offered by a psychiatric or psychological outpatient or community based program* under hospital jurisdiction, and as such, psychological or psychiatric treatment is provided by members within the aforementioned programs.

Based on the recommendation of the Provincial Ambulatory Care Advisory Group, data reporting for all mental health service recipients who seek the services offered by a psychiatric or psychological outpatient or community based program* will be based on individual **CONTACTS.**

A contact is defined as the occurrence of an interaction between a mental health service recipient and a mental health service provider.

WHO SHOULD USE MENTAL HEALTH INTERVENTION CODES: The mental health intervention codes identified in Section 2 of this manual are to be used when care is provided out of an organized mental health program to a mental health service recipient.

*Does not include patient activity from 76 Mental Health Clinics previously under the jurisdiction of the Alberta Mental Health Board.

Visit Examples – Ambulatory Care

The following examples apply to the reporting of ambulatory care data.

1. Visit By A Service Recipient To Day/Night Care Area

The Day/Night Care area is identified with one ambulatory care functional centre code that describes the care provided to the service recipient.

Example: A service recipient has a carpal tunnel release performed in Day/Night Care.

The functional centre code is reported at the level the facility uses internally. Only one visit is reported.

INTENT: For ambulatory care reporting, the services received are <u>not</u> fragmented into operating room, recovery room and pre/post care, and only one visit is reported.

Visit Examples & Coding Standards

2a. Multiple Visits By Same Service Recipient To Different Ambulatory Care Functional Centres

A service recipient may visit more than one ambulatory care service area within a 24 hour period. Separate visits must be reported for each area providing service recipient care unless diagnostic services included in MIS functional centres 71415 (Diagnostic Imaging), 71425 (Electrodiagnosis), and 71430 (Other Diagnostic Laboratories) are performed in conjunction with another ambulatory care visit. In those cases, the services are reported as part of the related ambulatory care visit (i.e. are not reported as an additional visit). Reporting "stand alone" visits to areas with an MIS code starting with 71425 or 71430 are optional to report.

Example (i): A service recipient is seen in Emergency with a gastrointestinal bleed. Service recipient is transferred to Day/Night Care for an esophagogastroduodenoscopy.

Report two visits, one for Emergency services and one for Endoscopy services.

Example (ii): A service recipient is seen in the morning at the Ophthalmology Clinic for a cataract. The service recipient went home, but returned later in the day to Emergency after slipping on the sidewalk, and sustaining a fractured thumb.

Report two visits, one for Ophthalmology services and one for Emergency services.

Example (iii): A service recipient is seen in Emergency for chest pain. An ECG is ordered and performed in the ECG lab (MIS functional centre 714302020).

Report one visit for Emergency services which may include the CCI code for ECG (optional coding if not an ACCS intervention).

INTENT: A service recipient may attend multiple ambulatory care service areas during a 24-hour period. A separate visit is reported for each attendance at a different service area unless the service area has an MIS functional centre number starting with 71415, 71425 or 71430.

Visit Examples – Ambulatory Care

2b. Multiple Visits By Same Service Recipient To Same Ambulatory Care Service Area

A service recipient may visit the same ambulatory care service area more than once in a 24 hour period. Separate visits must be reported for each time an ambulatory care service area provides service recipient care.

Example (i): *An elderly service recipient is seen in Emergency at 0700 hours for lightheadedness due to acute viral infection. The same service recipient is seen in Emergency at 1000 hours for laceration sustained in a fall when the service recipient fainted.*

This service recipient is seen in Emergency twice within a 24 hour period. Report two visits.

Example(ii): *A service recipient was seen 4 times in a 24 hour period for IV therapy treatment.*

Report four visits.

INTENT: **A service recipient may visit the same ambulatory care service area more than once in a 24 hour period. A separate visit is reported for each time the functional centre provides service to the service recipient.**

Visit Examples – Ambulatory Care

3a. Same Service Recipient Seen By Multiple Service Providers In A Multidisciplinary Clinic (Identified As One Functional Centre)

When a service recipient is seen in a multidisciplinary clinic, separate visits are reported when the clinical services provided are diverse.

Example: *A service recipient is seen in a multidisciplinary Cardiac Rehabilitation Clinic. The service recipient is seen by a physician for assessment as well as by a physiotherapist and a clinical nutritionist.*

Report three ambulatory care visits.

INTENT: **Each contact in which clinical services provided are diverse should be reported as a visit in order to accurately reflect activity and allow for consistent data management.**

3b. Same Service Recipient Seen By Multiple Service Providers In One Ambulatory Care Service Area

Generally, only one visit is reported when a service recipient sees several health service providers during an attendance at an ambulatory care area such as Emergency or Day/Night Care. An exception to this is when service providers who are not routinely involved in the provision of service recipient care in that service area, do deliver service recipient care.

Example (i): *A service recipient is seen in Surgery clinic by a physician and nurse for assessment of uterine prolapse.*

Report one ambulatory care visit.

Example (ii): *A service recipient is seen in Emergency by an emergency physician, a nurse and a respiratory therapist for assessment and treatment of an asthma attack.*

Report two visits.

Example (iii): *A service recipient is seen in Emergency by a general practitioner and a psychologist for assessment and treatment of depression.*

Report two visits.

INTENT: **A visit to an ambulatory care service area may include contact with a number of service providers and generally only one visit is reported unless care is also provided by a health service provider not routinely involved in the provision of care in that area.**

Visit Examples – Ambulatory Care

4. Service Recipient Seen In Ambulatory Care Service Area And Admitted

When a service recipient visits an ambulatory care service area and is subsequently admitted, an ambulatory care visit is reported.

Example: A service recipient is seen in Emergency with a diagnosis of myocardial infarction. The service recipient is then admitted to hospital.

This is considered an ambulatory care visit.

INTENT: If a service recipient visits an ambulatory care service area and is then admitted, a visit is reported for the ambulatory care service. The ACCS grouper recognizes unexpected admissions as a high resource element.

5. Service Recipient Left Without Being Seen, No Show, or Against Medical Advice

Although a "true" service is not provided, a visit is reported if a service recipient is registered but leaves prior to being seen by a service provider.

Example (i): A service recipient is registered in Emergency, however leaves prior to being seen.

Although a "true" ambulatory care service is not provided, a visit is reported for management purposes, to indicate the number of service recipients leaving prior to being seen. Report a disposition of "9" (Left without being seen by a professional service provider) for these scenarios.

A visit is not reported if a service recipient fails to show for treatment.

Example (ii): A service recipient is scheduled to visit the General Psychiatry Clinic, but fails to show.

This is <u>not</u> considered an ambulatory care visit.

If a service recipient receives some care by a service provider but leaves prior to the intended care being completed, a visit should still be reported.

Example (iii): A service recipient is seen in Emergency complaining of a severe headache and receives a comprehensive nursing examination, but leaves prior to seeing a physician, as intended.

This is considered an ambulatory care visit. Report a disposition of "3" (Left against medical advice) for these scenarios.

INTENT: The statistics of service recipients who leave without being seen or are no shows are important management information and provide critical information for quality assurance and service recipient satisfaction reviews. Cases reported with a disposition of "9" (Left without being seen) <u>will not</u> be used as a basis for funding.

Visit Examples – Ambulatory Care

6. Service Recipient Referred In From Another Facility (Excluding Laboratory And Investigative Technology Services)

When an inpatient from another facility is seen at an ambulatory care functional centre, a visit is reported. The delivery organization at which the service recipient is an inpatient must be identified (i.e. Institution From).

Example(i): A service recipient is an inpatient at one acute care hospital. He/she is referred to the Oncology ambulatory care service area at another acute care hospital.

This is considered an ambulatory care visit (at the ambulatory care service area of the second hospital).

Example(ii): A service recipient is an inpatient at your own acute care facility. He/she is referred to the Rheumatology ambulatory care service area at your facility.

This is not considered an ambulatory visit.

Workload associated with inpatients is captured under MIS for supporting inpatient costs. Inpatient funding "bundles" services provided for inpatients in all settings within the hospital during their stay.

Example(iii): A service recipient is a resident at a nursing home (attached to an acute care facility). He/she is referred to Emergency ambulatory care service area at the acute care facility.

This is considered an ambulatory care visit.

INTENT: Report a visit for an inpatient from another facility to identify the ambulatory care services provided. Do not report a visit to an ambulatory care service area for an inpatient from your acute care facility. The ACCS grouper reporting is intended to record purely ambulatory care visits.

Visit Examples – Ambulatory Care

7a. Telephone Visits

Telephone visits are considered to be reportable ambulatory care visits when they replace a face-to-face visit and are worthy of clinical documentation.

Example (i): A service recipient is contacted by telephone to obtain pre-surgical information from staff in the Pre-Admission Clinic.

Report one visit.

Example (ii): A service recipient is contacted by telephone by a physical therapist to determine how he tolerated his treatment yesterday and if further sessions are required.

Report one visit.

Example (iii): A service recipient is contacted by telephone to arrange for an appointment to be seen in the Diabetes Clinic.

This is ***not*** considered an ambulatory visit.

INTENT: Report a telephone call as an ambulatory care visit if clinical documentation occurs and all data elements including diagnosis can be completed.

Visit Examples – Ambulatory Care

7b. Videoconference (Telehealth) Visits

Videoconference (telehealth) visits are considered to be reportable ambulatory care visits when they replace a face-to-face visit and are worthy of clinical documentation.

Only the site providing the telehealth service must report an ambulatory care visit unless professional services paid for by the region are also provided at the site where the service recipient is located. In that instance, both sites must report a visit and enter a provider in the "Provider Type" field. If professional services paid for by the health region are not provided, telehealth services are optional to report. If the region chooses to report these telehealth services, the "Provider Type" field must be left blank.

Examples:

(i) An unaccompanied service recipient at one site receives telehealth services from a psychologist at another site whose services are paid for by the region.

Report one visit at the site where the psychologist is (Provider type must be entered). It is optional to report the visit for the unaccompanied service recipient (Provider type field must be left blank).

(ii) A service recipient, accompanied by a Speech Language Pathologist, receives telehealth services from a Speech Language Pathologist at another site. Both service providers are paid by their respective health regions.

Report two visits (Provider type must be entered).

(iii) An unaccompanied service recipient receives telehealth services from a physician who does not receive payment from the health region.

This visit is optional to report (Provider type field must be left blank).
`

(iv) A service recipient had an ultrasound performed at one site using telehealth (i.e. the ultrasound was performed under the guidance of a radiologist at another site). No other services were provided. The radiologist providing the ultrasound guidance is a regional employee.

Report two visits, including one Discrete DI visit for the site where the service recipient was located and a videoconference visit for the site where the radiologist providing guidance was located.

INTENT: Report a videoconference call as an ambulatory care visit if clinical documentation occurs and all data elements including diagnosis can be completed.

Visit Examples – Ambulatory Care

8. Service Recipient Seen By Physician In Consultation

When a service recipient is seen by a physician in consultation, an additional visit is not reported for the assessment completed by the consultant.

Example: A *service recipient is seen in Emergency by an emergency physician for numbness in the left side of the body. A neurologist is called in to complete a consultation to assist in obtaining a definitive diagnosis.*

Report one visit.

INTENT: **Only the care provided by the emergency physician is reported. The consultation completed by the neurologist is not reported as a visit because the clinical services provided are not considered as diverse. Note that consultations completed by other service providers such as psychologists are reported as separate visits.**

9. Service Recipient Seen By Multiple Physicians in the Same Clinic

When a service recipient is seen by multiple physicians in the same clinic, only one visit is reported.

Example: *A service recipient has a diagnosis of lupus erythematosis and sees a rheumatologist and a dermatologist.*

Report one visit.

INTENT: **Only one visit is reported which includes services provided by all physicians.**

Visit Examples – Ambulatory Care

10. Clinical Lab Procedures

When a service recipient receives clinical laboratory services (i.e. blood work, urinanalysis), a visit is not reported.

The ACCS grouper assumes the presence of clinical laboratory services and the costs of these are "bundled" into the cells. Hence, clinics, emergencies and procedure rooms are not required to report laboratory tests ordered.

For the purposes of management and funding, Lab services will be bundled into the weights for inpatient and outpatient groupers.

Example: *Service recipient is seen in the Family Medicine clinic and receives orders for laboratory work and a chest x-ray. The clinic would report the chest x-ray but not the laboratory work as part of the data elements required for the ACCS grouper.*

Visit Examples – Ambulatory Care

11. Visits For Diagnostic Imaging Service Only (Discrete DI)

When a service recipient visits an ambulatory care service area and receives diagnostic imaging services only (i.e. a Discrete DI visit), an ambulatory care visit is reported.

Example (i): A service recipient is seen in a physician's office and asked to go to the hospital to have a DI service performed.

Report a visit when the DI service is performed using the standard ambulatory care minimum data set. Report Mode of Service category "9" – Discrete DI.

Example (ii): A service recipient is seen in hospital A Emergency Department and referred to Hospital B for DI service.

At Hospital A, report an ambulatory care visit.

At Hospital B, report a visit when the service is performed using the standard ambulatory care minimum data set. Report Mode of Service category "9" – Discrete DI.

Example (iii): A service recipient is scheduled to have a CT Scan performed at a hospital Diagnostic Imaging Department. An IV, required to perform the examination, is inserted in the Emergency Department. The CT Scan is then performed.

If the service recipient is not registered as an Emergency patient, only one visit is reported.

Example (iv): A service recipient is a patient in a long term care facility and is sent to a hospital's Diagnostic Imaging Department for a DI service.

Report a visit when the DI service is performed using the standard ambulatory care minimum data set. Report Mode of Service category "9" – Discrete DI. **Note:** Reporting is the same regardless if the long term care facility is attached or is not attached to the hospital where the DI service is performed.

INTENT: Reporting visits for diagnostic imaging services results in a complete data set of ambulatory care diagnostic imaging activity being available for analysis and funding allocations.

Visit Examples – Ambulatory Care

12. Visits for Private Clinics

When a service recipient visits a private clinic for ambulatory care services, a visit is reported if the services provided are funded by the region.

Example (i): A service recipient is seen in a private rehabilitation clinic where services are provided for an injury covered by Workers' Compensation insurance.

A visit is optional to report, as regional dollars are not being used to cover the services provided. A visit may be reported by the private clinic if desired.

Example (ii): A service recipient is seen in a private physical therapy clinic for gait training post fracture. The services are covered through the region's funding received from Alberta Health and Wellness.

A visit is reported as regional dollars are used to cover the cost of the services provided.

INTENT: Only those visits seen in private clinics that are covered through regional funding are required to be reported. Reporting other service recipient activity is optional.

Visit Examples – Mental Health Care

The following mental health visit examples apply to the reporting of data for the ACCS grouper.

13. Data Reported On A Contact Basis

Example: *Service recipient diagnosed with schizophrenia is seen in Psychiatric Ambulatory Care Services by a psychologist for individual therapy and a psychiatric nurse for medication administration.*

Report two visits on a contact basis.

INTENT: **If a service recipient receives services offered by a psychiatric or psychological outpatient program under hospital jurisdiction, data is reported on a contact basis for each service provider*.**

14. Data Reported On A Visit Basis

Example: *Service recipient is seen in the Emergency Department by Family Practitioner and nursing personnel. Diagnosis of depression is made and medication prescribed.*

Report one ambulatory care visit.

INTENT: **If a service recipient receives services outside of a psychiatric or psychological outpatient program under hospital jurisdiction*, data is reported on a visit basis. This is considered an ambulatory care service recipient, not a mental health service recipient.**

*Does not include patient activity from 76 Mental Health Clinics previously under the jurisdiction of the Alberta Mental Health Board.

15. Use Of Mental Health Intervention Codes

Example (i): *An occupational therapist provides treatment to a mental health service recipient out of an organized mental health program.*

This is a visit by a mental health service recipient. The occupational therapist would use the mental health intervention codes from Section 2 rather than the rehabilitation intervention codes from Section 2.

Example (ii): *A General Practitioner treats a service recipient diagnosed with depression in the Emergency Department.*

This is a visit by a non mental health service recipient. The General Practitioner would <u>not</u> use the mental health intervention codes from Section 2.

INTENT: **When care is provided out of an organized mental health program to a mental health service recipient, the mental health intervention codes identified in Section 2 should be used.**

Coding Standards- Diagnoses Coding

I. Use the most pertinent ICD-10-CA code(s) from A00.0 to Z99.9 to identify diagnoses, signs, symptoms, conditions, complaints, problems, or other reasons for the ambulatory care service being provided.

A. The health care providers should document the service recipient's condition using terminology which best describes the specific diagnoses, symptoms, problems, or reason for the service.

Codes from A00.0 to Q99.9 and S00.0 to T98.3 are used to classify confirmed or queried diseases and injuries. Codes R00.0 to R99 are used when an established or probable diagnosis is not known and only symptoms, signs, or abnormal clinical and laboratory findings are documented.

B. When circumstances other than a disease, injury, or external cause classifiable to categories A00 to Y89 are recorded as the reason for service, codes Z00.0 to Z99.9, Factors Influencing Health Status and Contact with Health Services, are used. Coding the underlying condition requiring the service, when documented, is encouraged.

Example (i):

Service recipient is seen for reprogramming of a cardiac pacemaker for Sick Sinus Syndrome.

Assign the following information:

Code Sequence	Code	Code Description
1	Z45.0	Adjustment and management of cardiac pacemaker
2	I49.5	Sick sinus syndrome

Example (ii):
Routine follow-up care following surgical intervention for change of dressings, checking wound healing process, or removal of sutures and no mention of infection or other complications.

Assign the following information:

Code	Code Description
Z48.0	Attention to surgical dressings and sutures

Coding Standards - Diagnoses Coding

Example (iii):

Service recipient is seen for prophylactic vaccination for rubella.

Assign the following information:

Code	Code Description
Z24.5	Need for immunization, against rubella alone

Example (iv):

Service recipient is seen after the initial treatment of a fracture for cast replacement.

Assign the following information:

Code Sequence	Code	Code Description
1	Z47.8	Other specified orthopedic follow-up care
2		Appropriate fracture code

II. Code diagnoses documented as probable, or to be ruled out but not established, with a diagnosis prefix of "Q" (query diagnoses).

Example:

Service recipient is seen for headache at which time the physician notes a questionable right-sided weakness. A CT scan is ordered and physician documents "rule out brain tumor."

Note: CIHI's ambulatory care coding standard indicates that probable, suspected, questionable, query, rule out, working or differential diagnoses should not be coded. In these instances, please follow the Alberta coding standard (i.e. code the condition with a diagnosis prefix of "Q").

Coding Standards - Diagnoses Coding

Assign the following information:

Diagnosis Prefix	Code	Code Description
Q	D43.2	Neoplasm of uncertain or unknown behavior of brain, unspecified

Signs and symptoms that are followed by contrasting or comparative diagnoses should be coded so that a symptom is the Main Ambulatory Care Diagnosis. Code also all the contrasting diagnoses as suspected diagnoses.

Example:

Service recipient is seen for chest pain. The physician is unsure of the cause of the pain and documents " chest pain, due to either angina or esophageal spasm."

Assign the following information:

Code Sequence	Diagnosis Prefix	Code	Code Description
1		R07.4	Chest pain, unspecified
2	Q	I20.9	Angina pectoris, unspecified
3	Q	K22.4	Dyskinesia of esophagus

III. Code and report chronic diseases and conditions treated on an ongoing basis as many times as the service recipient receives related care. The chronic disease/condition may or may not be coded as the main ambulatory care diagnosis.

Example:
Service recipient with rheumatoid arthritis is seen repeatedly in Rheumatology Clinic.

Coding Standards - Diagnoses Coding

Assign the following information:

Code	Code Description
M06.9	Rheumatoid arthritis, unspecified site

IV. For service recipients receiving ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is different from the preoperative diagnosis, select the postoperative diagnosis for coding.

Example:

Service recipient with clinical assessment of appendicitis has appendectomy. Results from surgery indicate a normal appendix.

Assign the following information:

Code	Code Description
R10.4	Other and unspecified abdominal pain

V. For service recipients receiving therapeutic services[1] only, the appropriate Z code for the service is sequenced first. If documented, the diagnosis or problem previously established is coded as a secondary diagnosis.

Example (i):

Service recipient with obesity is seen for dietary counseling.

Assign the following information:

Code Sequence	Code	Code Description
1	Z71.3	Dietary counseling and surveillance
2	E66.9	Obesity, unspecified

[1] Therapeutic services include those services provided by Clinical Nutrition, Physical Therapy, Occupational Therapy, Social Work, etc.

Coding Standards - Diagnoses Coding

Example (ii):

Cancer service recipient is seen solely for chemotherapy.

Assign the following information:

Code Sequence	Code	Code Description
1	Z51.1	Chemotherapy session for neoplasm
2		Appropriate code for malignancy

Example (iii):

Service recipient is seen solely for IV medication for treatment of cellulitis of the arm.

Assign the following information:

Code Sequence	Code	Code Description
1	Z51.2	Other chemotherapy
2	L03.10	Cellulitis of upper limb

Example (iv):

Service recipient with chronic renal failure is seen solely for hemodialysis.

Assign the following information:

Code Sequence	Code	Code Description
1	Z49.1	Extracorporeal dialysis
2	N18.9	Chronic renal failure, unspecified

Coding Standards - Diagnoses Coding

Example (v):

Service recipient is seen for physiotherapy after a current cruciate ligament tear resulting from overexertion.

Assign the following information:

Code Sequence	Code	Code Description
1	Z50.1	Other physical therapy
2	S83.591	Sprain and strain of unspecified cruciate ligament of knee

NOTE: The codes to be used as the main ambulatory care diagnosis for the rehabilitation disciplines are as follows:

Audiology	Z01.1
Physical Therapy	Z50.1
Occupational Therapy	Z50.7
Recreational Therapy	Z50.8
Speech Language Pathology	Z50.5
Respiratory	Z50.9

VI. For service recipients receiving diagnostic services[2] only, the appropriate Z code for the examination is sequenced first. If documented, the diagnosis or problem for which the services are being performed is sequenced second.

Example:

Service recipient was referred to the hospital Diagnostic Imaging Department for an MRI of the head with the reason for the examination identified as query multiple sclerosis.

[2] Diagnostic services include diagnostic testing such as diagnostic imaging, exercise stress test, Holter monitor, ECG, EMG, pulmonary function test, etc.

Coding Standards - Diagnoses Coding

Assign the following information:

Code Sequence	Diagnosis Prefix	Code	Code Description
1		Z01.6	Radiological examination, not elsewhere classified
2	Q	G35	Multiple sclerosis

Note: All Discrete Diagnostic Imaging visits should have Z01.6 reported as the main ambulatory care diagnosis.

VII. Use Z01.8, Other specified special examinations, for service recipients receiving preoperative evaluations only, sequenced first.

The code(s) for the condition describing the reason for the surgery and any findings from the evaluation are sequenced as secondary diagnoses.

Example:

Service recipient diagnosed with cholelithiasis is seen in Preoperative Assessment Clinic.

Assign the following information:

Code Sequence	Code	Code Description
1	Z01.8	Other specified special examination
2	K80^^	Cholelithiasis

Coding Standards - Diagnoses Coding

VIII. Code routine follow-up visits after completed treatment to category Z08, Follow-up examination after treatment for malignant neoplasm, or Z09, Follow-up examination after treatment for conditions other than malignant neoplasms. Assign the Z codes for history of the disease or status, if applicable, as secondary diagnoses.

Example:

Service recipient 3-years post-mastectomy is seen for routine check. No recurrence of malignant neoplasm is found.

Assign the following information:

Code Sequence	Code	Code Description
1	Z08.0	Follow-up examination after surgery for malignant neoplasm
2	Z85.3	Personal history of malignant neoplasm of breast

Coding Standards - Injury Coding

Current Injury

A newly diagnosed injury where intended initial intervention may or may not have commenced but has not yet been completed.

Aftercare

Care for service recipients who have already been treated for an injury and are receiving care to consolidate the treatment, to deal with residual states, or to prevent recurrence.

Follow-up

Surveillance only following completed treatment.

Late Effect

A current condition in the service recipient that is caused by a previous condition, illness or injury. The previous condition is no longer present.

Old/Non Current

Injury for which the initial intended treatment has been completed. Intended initial treatment can be medical or surgical and also can be a multi-stage process.

- **Determination of the correct category is based on the course of the treatment and is independent of time frames.**
- **Use of the terminology "follow-up" by physicians does not always indicate a follow-up code should be used.**
- **Often physicians will give a diagnosis of a current injury when the reason for the visit is aftercare or follow-up.**

Examples of Injury Coding

1. *Service recipient presents to the Emergency Department with a foreign body, eye. After assessment diagnosis of corneal abrasion is made, foreign body is removed and eye patch applied.*
   CODE AS CURRENT INJURY

   Service recipient presents to Emergency Department two days later for recheck. Patch is removed, eyedrops instilled and eye repatched.
   CODE AS AFTERCARE (treatment has not yet been completed)

Coding Standards - Injury Coding

The following day, service recipient returns to Emergency Department for reassessment. Patch is removed and abrasion is healing.
CODE AS FOLLOW-UP

2. *Service recipient presents to the Emergency Department with a foreign body, eye. After assessment diagnosis of corneal abrasion is made, foreign body is removed and eye patch applied.*
CODE AS CURRENT INJURY

Service recipient returns to Emergency Department for reassessment, the following day. Patch is removed and rust ring is found. Eye is repatched.
CODE AS LATE EFFECT (following late effect coding standards)

The following day, service recipient returns to Emergency Department for reassessment. Patch is removed and abrasion is healing.
CODE AS FOLLOW-UP

3. *Service recipient presents to the Emergency Department with a foreign body, eye. After assessment diagnosis of corneal abrasion is made, foreign body is removed and eye patch applied.*
CODE AS CURRENT INJURY

Service recipient presents two weeks later to the Emergency Department with foreign body sensation. Examination reveals retained intraocular foreign body that is then removed.
CODE OLD/NON CURRENT INJURY

Service recipient returns to Emergency Department for reassessment, the following day. Patch is removed and abrasion is healing.
CODE AS FOLLOW-UP

4. *Service recipient presents to Emergency Department with a knee injury following a skiing accident. On examination, diagnosed with a torn anterior cruciate ligament.*
CODE AS CURRENT INJURY

Service recipient is admitted as an inservice recipient and repair of ligament is performed. Four weeks later, service recipient attends orthopedic outservice recipient clinic for post-op check.
CODE AS AFTERCARE

Coding Standards - Injury Coding

Two months following surgery, the brace is removed in the orthopedic outservice recipient clinic.
CODE AS AFTERCARE

Service recipient presents to clinic in two weeks for final assessment and no problems found.
CODE AS FOLLOW-UP

5. *Service recipient presents to the Emergency Department with a knee injury following a skiing accident. On examination, diagnosed with a torn anterior cruciate ligament. A Jones bandage is applied and service recipient is referred to family physician for follow-up*
CODE AS CURRENT INJURY

Eight months later, the service recipient is admitted to day surgery for repair of ligament.
CODE AS OLD/NON CURRENT INJURY

Coding Standards - Intervention Coding

Intervention Definition

Includes all therapeutic (generally performed in an operating room or designated procedure location), diagnostic and clinical interventions.

Fundamental Standards For Coding Interventions

1. Use the most pertinent *CCI* code(s) from 1.AA.13.HA-C2 to 8.YA.70.HB-BA to identify the interventions performed.
2. For data reporting purposes, interventions are sequenced in order of the most significant to least significant.
3. The intervention with the highest weight is the one CCI code considered to be the most **significant** intervention performed during the service recipient's visit (the ACCS grouper will loop through interventions to determine the highest weighted intervention).
4. When two interventions are both considered to be of equal significance, select the intervention that relates to the Main Ambulatory Care Diagnosis as the most significant.
5. Ten (10) interventions may be reported and are left-justified.

Example (i):
Service recipient admitted with a diagnosis of senile cataract; phacoemulsification of cataract and insertion of rigid lens prosthesis was performed in the operating room.

Assign the following information:

Code	Code Description
1.CL.89.VR-LN	Phacoemulsification with posterior chamber rigid prosthesis inserted

Coding Standards - Intervention Coding

Example (ii):
Service recipient admitted for dilatation and curettage and subsequent endoscopic bilateral tubal ligation.

Assign the following information:

Code Sequence	Code	Code Description
1	1.RM.87.CA-AE	Excision partial, uterus and surrounding structures using curette (dilatation and curettage) per orifice
2	1.RF.51.DA-LV	Occlusion, fallopian tube using ligature

Example (iii):
Service recipient admitted for hernia repair, but intervention was not carried out as service recipient was noted to be in respiratory distress.

Assign: CANCELLED in the intervention code area (Must be left-justified and entered in upper case letters)

CANCELLED is reported for day surgery interventions only.
For cases where the intended intervention is abandoned after administration of anaesthesia, incision, inspection or biopsy, assign codes for the interventions performed followed by the code for the intended intervention with the status attribute “A” indicating abandoned.

STANDARDS FOR ASSIGNING Z CODES FOR AMBULATORY CARE ACTIVITY

The following information is intended to provide guidance and direction for ICD-10-CA Z code assignment for ambulatory care reporting.

Z codes, the classification of Factors influencing health status and contact with health services, are provided to deal with visits when circumstances other than a disease or injury classifiable to categories A00 through Y89 are recorded as reasons for encounters with a service provider.

There are two primary circumstances for the use of Z codes:

- When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination or to discuss a problem which is in itself not a disease or injury.
- When some circumstance or problem is present which influences the person's health but is not in itself a current illness or injury. Such factors may be elicited during population surveys, when the person may or may not be currently sick, or be recorded as an additional factor to be borne in mind when the person is receiving care for some illness or injury.

1. Contact/exposure

Category Z20 indicates contact with, or exposure to communicable disease. These codes are for service recipients who do not show any sign or symptom of a disease but have been exposed to a disease by close personal contact with an infected individual or are in an area where a disease is epidemic.

If an inoculation is given, assign a Z code from the Immunizations category (Z23-Z27) as the main ambulatory care diagnosis. A code from category Z20 may also be coded as a secondary diagnosis to indicate contact/exposure to a communicable disease.

2. Immunizations

Categories Z23-Z27 are used for visits for immunizations. They indicate that a service recipient is being seen to receive a prophylactic immunization against a disease. The injection itself may be represented by the use of the appropriate intervention code.

For circumstances where the patient is seen for a planned immunization, which is not carried out, assign the appropriate code from category Z28.

3. Status

Status codes indicate that a service recipient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. When the condition mentioned is still present or is still under treatment or a complication is present, a status code is not assigned. A status code is distinct from a history code. The history code indicates that the condition has resolved and no longer requires active treatment.

The status Z code/categories include:

Z00.2	Examination for period of rapid growth in childhood
Z00.3	Examination for adolescent development state
Z21	Asymptomatic HIV infection status This code indicates that a service recipient has tested positive for HIV but has not manifested signs or symptoms of the disease.
Z22^^	Carrier of infectious disease Carrier status indicates that a person harbors the specific organisms of a disease without manifested symptoms and is capable of transmitting the infection.
Z33	Pregnant state, incidental This code should only be used when the pregnancy is not related to the reason for the visit. If the pregnant state is responsible for the visit and/or requires care or monitoring, a code from the obstetric chapter (O00-O99) should be assigned.
Z89^^	Acquired absence of limb
Z90^^	Acquired absence of organs, not elsewhere classified
Z92.1-Z92.28	Personal history of long-term (current) drug use This subcategory indicates a service recipient's continuous use of a prescribed drug for the long-term treatment of a condition or for prophylactic use. It is not for use by service recipients who have drug addictions.
Z93^^	Artificial opening status
Z94^^	Transplanted organ and tissue status
Z95^^	Presence of cardiac and vascular implants and grafts
Z96^^	Presence of other functional implants
Z97^^	Presence of other devices
Z98^^	Other postsurgical states
Z99^^	Dependence on enabling machines and devices, not elsewhere classified

Categories Z89 and Z94-Z98 are for use only if there are no complications or malfunctions of the organ or tissue replaced, the amputation site, or the equipment on which the service recipient is dependent. These are usually secondary codes.

4. History (of)

There are two types of history Z codes: personal (Z85-Z88) and family (Z80-Z84).

Personal history codes explain a service recipient's past medical condition that no longer exists and for which no treatment is being received, but has the potential for recurrence and, therefore, may require continued monitoring.

Family history codes are for use when a service recipient has a family member(s) who has had a particular disease that causes the service recipient to be at higher risk of also contracting the disease.

Personal history codes are usually used secondary to follow-up codes and family history codes are usually used secondary to screening codes to explain the need for the visit.

The history Z codes/categories include:

Z80^^	Family history of malignant neoplasm
Z81^^	Family history of mental and behavioral disorders
Z82^^	Family history of certain disabilities and chronic diseases leading to disablement
Z83^^	Family history of other specific disorders
Z84^^	Family history of other conditions
Z85^^	Personal history of malignant neoplasm
Z86^^	Personal history of certain other diseases
Z87^^	Personal history of other diseases and conditions
Z88^^	Personal history of allergy to drugs, medicaments and biological substances
Z91^	Personal history of risk-factors, not elsewhere classified
Z92.3-Z92.9	Personal history of medical treatment

5. SCREENING

Screening is testing for disease or disease precursors in seemingly well service recipients so that early detection and treatment can be provided for those who test positive for the disease. Recommended screenings for many subgroups in a population include such things as:

- Routine mammograms for women over 40.
- Fecal occult blood test for everyone over 50.
- Amniocentesis to rule out a fetal anomaly for pregnant women over 35.
- Screening endoscopies in service recipients with a positive family history of malignancy.

The testing of a service recipient to rule out or to confirm a suspected diagnosis because of presenting signs or symptoms is a diagnostic examination, not a screening. In these cases, the sign or symptom code is used to explain the reason for the test.

Should a condition be discovered during the screening, the code for the condition should be used. The screening code should not be assigned.

The Z code indicates that a screening exam is planned. An intervention code may also be reported to identify the screening performed.

The screening Z code categories include:

Z11^^-Z13^^	Special screening examinations
Z36^^	Antenatal screening

6. OBSERVATION

This category is to be used when service recipients without a diagnosis are suspected of having an abnormal condition with signs or symptoms, which requires study, but after examination and observation, is found not to exist. This category is also for use for administrative and legal observation status.

The observation Z code category is:

Z03^^	Medical observation and evaluation for suspected diseases and conditions

7. AFTERCARE

This category is to be used when service recipients, who have already been treated for a condition, receive care to consolidate the treatment, to deal with residual states, or to prevent recurrence.

The aftercare Z code categories include:

Z42 ^^	Follow-up care involving plastic surgery
Z43^^	Attention to artificial openings
Z44^^	Fitting and adjustment of external prosthetic device
Z45^^	Adjustment and management of implanted device
Z46^^	Fitting and adjustment of other devices
Z47^^	Other orthopedic follow-up care
Z48^^	Other surgical follow-up care
Z49^^	Care involving dialysis
Z50^^	Care involving use of rehabilitation procedures
Z51^^	Other medical care

8. FOLLOW-UP

The follow-up codes are used to explain surveillance following **completed** treatment of a disease, condition, or injury. Should a condition be found to have recurred on the follow-up visit, then the code reflecting the active condition should be used.

The follow-up Z code categories include:

Z08^^	Follow-up examination after treatment for malignant neoplasm
Z09^^	Follow-up examination after treatment for conditions other than malignant neoplasms
Z39^^	Postpartum care and examination

9. DONOR

Category Z52 includes the donor codes. They are used for living individuals who are donating blood or other body tissue. They are not to be used to identify cadaveric donations.

10. COUNSELING

Counseling Z codes are used when a service recipient or family member receives advice or counseling.

The counseling Z codes/categories include:

Z30.0	General counseling and advice on contraception
Z31.5	Genetic counseling
Z31.6	General counseling and advice on procreation
Z70^^	Counseling related to sexual attitude, behavior and orientation
Z71^^	Persons encountering health services for other counseling and medical advice, note elsewhere classified

11. CONTRACEPTION, PROCREATION, OBSTETRICS, AND RELATED CONDITIONS

Z codes for pregnancy are used in those circumstances when none of the problems or complications included in the codes from the obstetrics chapter exist. Z codes from these categories should be used to reflect a visit for prenatal, normal delivery or postpartum care.

Z code/categories for this section include:

Z30^^	Contraceptive management
Z31^^	Procreative management
Z32^^	Pregnancy examination and test
Z33	Pregnant state, incidental
Z34^^	Supervision of normal pregnancy
Z35^^	Supervision of high-risk pregnancy
Z37^^	Outcome of delivery
Z39^^	Postpartum care and examination

Refer to Section 5: Screening for use of codes in category Z36 (Antenatal screening)

12. NEWBORN, INFANT, AND CHILD

Newborn Z codes/category include:

Z00.1	Routine child health examination
Z38^^	Liveborn infants according to place of birth
Z76.1	Health supervision and care of foundling
Z76.2	Health supervision and care of other healthy infant and child

13. ROUTINE AND ADMINISTRATIVE EXAMINATIONS

These Z codes allow for the description of encounters for routine examinations, such as a general check-up or examinations for administrative purposes, such as a pre-employment physical. The codes are not to be used if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases, the diagnosis code is used. During a routine exam, if a diagnosis or condition is discovered, that diagnosis or condition should be coded as an additional code. Codes for pre-existing and chronic conditions, as well as history codes, may also be coded as secondary codes provided the examination is for administrative purposes and not focused on any particular condition.

Preoperative examination Z codes are for use only in those situations when a service recipient is being cleared for surgery and no treatment is given.

The Z code/categories for routine and administrative examinations include:

Z00^^	General examination and investigation of persons without complaint and reported diagnosis
Z00.1	Routine child health examination
Z01^^	Other special examinations and investigations of persons without complaint or reported diagnosis (Note: Z01.6 and Z01.7 may also be assigned to visits for examinations for diagnosis of a suspected condition.)
Z02^^	Examination and encounter for administrative purposes
Z10^^	Routine general health check-up of defined subpopulation

14. PERSONS WITH POTENTIAL HEALTH HAZARDS RELATED TO SOCIOECONOMIC AND PSYCHOSOCIAL CIRCUMSTANCES

Categories Z55-Z65 include circumstances that a service recipient has experienced in the past, or is currently experiencing, that have the potential to affect that service recipient's health. The circumstance may or may not be the main focus of the service provided at the time of the visit.

15. ADDITIONAL Z CODES

Additional Z codes describe a number of other health care visits that do not fall into one of the preceding categories. Some of these codes identify the reason for the visit while others are for use as additional codes that provide useful information on circumstances that may affect a service recipient's care and treatment.

Visit Examples & Coding Standards

Additional Z code/categories include:

Z04^^	Examination and observation for other reasons
Z29^^	Need for other prophylactic measures
Z40^^	Prophylactic surgery
Z41^^	Procedures for purposes other than remedying health state
Z53^^	Persons encountering health services for specific procedures, not carried out
Z54^^	Convalescence
Z72^^	Problems related to lifestyle
Z73^^	Problems related to life-management difficulty
Z74^^	Problems related to care-provider dependency
Z75^^	Problems related to medical facilities and other health care
Z76^^	Persons encountering health services in other circumstances (excluding Z76.1 and Z76.2)
Z92.0	Personal history of contraception

Tab:

Summary of Reporting Changes for 2005/2006

Summary of Changes Effective April 1, 2005

Page	Data Element	Change
2		Revised ACCS Schematic ("Service Recipient Left Without Being Seen moved up to the second step of the decision tree)
17	Visit example 7b	Modified to reflect changes in reporting of videoconferences
49	Personal Health Number	For Manitoba, field length changed from 6 to 9 digits
51	Responsibility for Payment	Modified descriptions for code "05" and "06" to match inpatient descriptions
58	Provider Type	Added codes: 04214 - Early Childhood Development Therapist 09972 - Rehabilitation Practitioner 09973 - Genetics Counsellor 09974 - Independent Living Support Worker 99999 - No Clinical Provider
63	Anaesthetic Type	Added code "0" (OOH intervention)
69	Triage Level	Modified to include mandatory reporting of triage levels in regional hospital emergency rooms.
74	Residence Name	Removed Hobbema I.R. Added Springbrook
Section 1	List of Major Ambulatory Care Categories	Added new section: Major Ambulatory Care Categories (MACs)
Section 2	List of ACCS Grouper Cells	Added a new ACCS group: 1078 Reassessment - Mental Health
Section 5 and 8	ACCS/CCI intervention Codes and ACCS Groups	Added: CCI code 5CA88HAA2 (ACCS Group 42) Alberta Developed Attribute Code 2AZ02ZZ, S=P, L=MH (ACCS Group 1078) (Code also added in Section 3) Section 5: Combined "Other Groups" Table with CCI Intervention Codes Table
Section 6	MIS Primary Accounts Valid in ACCS	See Section 6 for a detailed summary of changes
Section 7	Institution Number List	Revised List of Institution Numbers

Tab:

Data Elements

Mandatory Data Elements

Overview:
This section of the Alberta Ambulatory Care Reporting Manual lists the mandatory data elements first, followed by optional data elements thereafter. Additional fields that exist on the file layout, but are Non-Abstracted Data Elements are listed on the last page of this section.

Also, the following technical specifications are displayed for each data element. The specifications are provided to assist users/programmers in understanding the file record layout.

- SF# — Start byte of field in the ambulatory care file layout
- Status — M = Mandatory, O = Optional
- Len — Length of field (number of characters)
- Format — A = Alphanumeric (means any letter or number is permitted), N = Numeric (means only digits 0 through 9 are permitted)
- LJ, RJ or N/A — Field justification (left, right or not applicable)
- All trim — No spaces before or after the data entered in a particular field.

1. Institution Number

(SF#2, Mandatory, Len=5, N, N/A)

The Institution Number identifies the delivery organization that is responsible for the provision of services to service recipients and is identified by a five digit, provincially assigned institution number. The first digit identifies the province of the reporting institution, and for Alberta, this is the value 8. The second digit identifies the level of care provided by the organisation and for ambulatory care reporting, this is also the value 8. The last three digits identify the organization number. (See Section 7 for institution numbers.)

Example: The reporting institution number for General Hospital ambulatory care is 88199

Mandatory Data Elements

2. Submission Period

(SF #11, Mandatory, Len=2, N, N/A)

The submission period identifies the month that the visit was initiated in. Submission periods range from 01 to 12 with the first submission period referring to the first period of the fiscal reporting year; that is April.

Valid values are:

Submission Period	Month
01	April
02	May
03	June
04	July
05	August
06	September
07	October
08	November
09	December
10	January
11	February
12	March

Example (i): The service recipient visited Emergency on May 06.
Submission Period = 02

Example (ii): The service recipient visited and was registered in Day/Night care on January 31 at 1800 hours and was discharged on February 1 at 0800 hours.
Submission Period = 10

3. Submission Number

(SF #13, Mandatory, Len=35, A, N/A)

The submission number should uniquely identify each record within a batch and must always be the unique identifier for that record across all years and periods for the reporting facility. The number does not need to be sequential. Must be zero filled, no blanks.

Example : Record number 2
00000000000000000000000000000000002

Mandatory Data Elements

4. Submission Type

(SF #48, Mandatory, Len=1, A, N/A)

Submission type identifies the type of action that should be taken with the submitted record. There are three types of record submission actions:

A Add record
C Change record
D Delete record

5. Unique Lifetime Identifier (ULI)

(SF #61, Mandatory, Len=9, A, N/A)

The Unique Lifetime Identifier (ULI) is a unique and permanent number assigned to all persons who receive health services in Alberta. ULIs are assigned to all Alberta residents, residents of other provinces/territories, and other countries. Alberta PHNs are ULIs that have been assigned to stakeholders upon registration and presumes eligibility for basic health services, as defined by the Alberta Health Care Insurance Plan.

Example (i): J. Blackburn's ULI (Alberta resident) 634571230

Example (ii): A. Peterson's ULI (Newfoundland resident) 406580010

ULIs are mandatory to report for emergency and day surgery visits. In cases where available patient information does not facilitate looking up a ULI in Person Directory or issuing a ULI, nine zeros (000000000) must be reported as the ULI. The ULI field should not be left blank in these situations.

ULIs should also be reported if available for outpatient clinic visits. If a ULI is not available for an outpatient clinic visit, the data element should be left blank.

6. Personal Health Number

(SF #70, Mandatory, Len=15, A, LJ)

The Personal Health Number (PHN) is the service recipient's unique health care coverage number as assigned by the Provincial Government of Residence. This field is completed for all residents of Canada.

The available entries include:

Mandatory Data Elements

- The service recipient's PHN as assigned by the province of residence. For out of province residents, record the out of province health care number, if available.

- **0** = Insured resident of Alberta, but the PHN is not available.

- **1** = Not applicable including those instances when the service recipient is out of province with an unavailable PHN, out of country, federal government coverage (e.g. RCMP, penitentiary inmate, veteran, etc.), or no health insurance coverage from province of residence.

- **9** = Stillbirth

Example (i): J. Blackburn's PHN (Alberta)
634571230_ _ _ _ _ _

Example (ii): A. Peterson's PHN (Newfoundland)
987654321012_ _ _

Example (iii): R. Johnson is an Alberta resident and forgot his PHN at home
0 _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Example (iv): P. Mathews is a Saskatchewan resident and does not have his PHN with him
1 _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Mandatory Data Elements

The field length for each provincial health number is as follows:

Alberta	9 digit Personal Health Number
British Columbia	10 digit Personal Health Care Number (12 digits for newborn)
Manitoba	9 digit Manitoba Health Registration Number
New Brunswick	9 digit Medicare Number
Newfoundland and Labrador	12 digit Medical Care Plan Number
Northwest Territories	8 digit Health Care Number (1 alpha and 7 numeric)
Nova Scotia	10 digit Medical Services Insurance
Nunavut	9 digit Health Care Number
Ontario	10 digit Health Care Number (12 digit with the version code)
Prince Edward Island	8 digit Health Care Number
Quebec	12 digit Health Care Number (4 alpha characters plus 8 numeric characters)
Saskatchewan	9 digit Hospital Service Number
Yukon Territory	9 digit Health Care Number (begin with 002)

7. Responsibility For Payment

(SF #85, Mandatory, Len=2, N, N/A)

The responsibility for payment for a visit is identified by a two digit code.

Valid values are:

Code	Description
01	Provincial / Territorial responsibility
02	Worker's Compensation Board / Worker's Service Insurance Board (WCB/WSIB)
03	Other province / territory (resident of Canada)
04	Department of Veteran Affairs (DVA), Veteran Affairs Canada (VAC)
05	First Nations and Inuit Health Branch (formerly called the Medical Service Branch, MSB)
06	Other federal government (RCMP, Department of National Defence, Penitentiary Inmates, Immigration)
07	Canadian resident self pay
08	Other countries self pay
09	Special Government Funded Program: Service recipients whose care is charged in part or in whole to a special Alberta government program (e.g. Program Unit Funding – PUF, Student Health Initiative Partnership – SHIP, regionally-identified Province Wide Services)
blank	Only valid when Health Care Number is equal to 9 (stillborn)

8. Postal Code

(SF #94, Mandatory, Len=12, A, LJ All trim)

The service recipient's postal code is a catchment number as assigned by Canada Post.

- **Resident of Canada:** If the postal code is known, enter the full six digit alphanumeric postal code as assigned by Canada Post. If the postal code is not known, report the two-alpha code from the table on the following page.
- **Non-resident of Canada:** Report the two-alpha code from the table below.
- **Transient/Homeless:** Report XX.

Two digit postal code valid values are:

Code	Location	Code	Location
NL	Newfoundland	AB	Alberta
NS	Nova Scotia	BC	British Columbia
NB	New Brunswick	YT	Yukon
PE	P.E.I.	NT	Northwest Territories
QC	Quebec	NU	Nunavut
ON	Ontario	US	USA
MB	Manitoba	OC	Other Country
SK	Saskatchewan	XX	Transient or Homeless

Example (i): The service recipient is a resident of Alberta but has no fixed address. His general mailing address is T9H 3E2.
The code assignment is T9H3E2_ _ _ _ _ _

Example (ii): The service recipient is a resident of Alberta but has no fixed address and no mailing address.
The code assignment is XX_ _ _ _ _ _ _ _ _ _

Example (iii): The service recipient is a visitor from Saskatchewan and cannot remember his postal code.
The code assignment is SK_ _ _ _ _ _ _ _ _ _

Example (iv): The service recipient is a resident of Alberta, however, for whatever reason, the postal code cannot be obtained.
The code assignment is AB_ _ _ _ _ _ _ _ _ _

Example (v): The service recipient is a resident of Germany,
The code assignment is OC_ _ _ _ _ _ _ _ _ _

9. Birth Date

(SF #106, Mandatory, Len=8, N, N/A)

The service recipient's birth date identifies when the service recipient was born. Reporting format is YYYYMMDD (year, month, day).

- If the year of birth is known but not the month and day, record the first day of the first month.

- If no part of the birth date is known and no estimate of the age can be made, assign the proxy date of January 01, 1901.

Example (i): The service recipient was born on July 27, 1964.
Report 19640727

Example (ii): The service recipient was born in 1960. Month and day were unavailable.
Report 19600101

Example (iii): No part of the service recipient's birth date is available, and no age was estimated.
Report 19010101

10. Gender

(SF #114, Mandatory, Len=1, A, N/A)

The valid values for gender are:

M Male
F Female
U Undifferentiated; for stillbirths only
O Other; for transsexuals or hermaphrodites

Mandatory Data Elements

11. Institution From

(SF #115, Mandatory, Len=5, N, N/A)

The institution from number is reported when the service recipient is transferred from **another** health care facility (includes other acute care facility, nursing home, lodge, etc.) for further treatment or hospitalisation.

Where no transfer from another institution occurs, the field is left blank.

If a transfer is involved, the Institution From number must be a five digit, provincially assigned number indicating the facility the service recipient was transferred from. This **does not include** transfer of a service recipient from inpatient to an ambulatory care service area within the same facility. (See Section 7 for institution numbers.)

Only where there is no provincially assigned institution number available should one of the following codes be reported:

Institution From Number	*Description*
88999	Out of province ambulatory care
89995	Nursing home
89996	Unclassified / unknown health institution
89997	Home care program
89998	Senior citizen's lodge
89999	Out of province or country acute care hospital

Example (i): The service recipient is transferred from General Hospital Emergency Department to Sunshine Hospital Endoscopy Day/Night care. Sunshine Hospital records the General Hospital's ambulatory care number as institution from.
General Hospital Ambulatory Care # 88199

Example (ii): The service recipient is transferred from General Hospital Inpatient Unit to Regional Hospital's Cardiac Clinic. Regional Hospital records General Hospital's inpatient number as institution from.
General Hospital's Inpatient # 80199

12. Admit Via Ambulance

(SF #120, Mandatory, Len=1, A, N/A)

Report this field if the service recipient is brought to a service delivery site by ambulance. Ambulance includes all licensed ambulances, inter-facility transfer service units and air ambulances having the capability of providing medical intervention to a service recipient en route to the destination.

Valid values are:

Code	Description
A	Air ambulance
G	Ground ambulance
C	Combination of air and ground ambulance
Blank	Patient did not arrive by ambulance

13. Institution To

(SF #121, Mandatory, Len=5, N, N/A)

The institution to number is reported when a service recipient is transferred to **another** health care facility (includes other acute care facility, nursing home, lodge, etc.) for further treatment or hospitalisation at the completion of the ambulatory care visit.

Where no transfer to another institution occurs, the field is left blank.

If a transfer is involved, the Institution To number must be a five digit, provincially assigned number indicating the facility the service recipient was transferred to. This **does not include** transfer of a service recipient to inpatient from an ambulatory care service area in your own facility. (See Section 7 for institution numbers.)

Only where there is no provincially assigned institution number available should one of the following codes be reported:

Institution To Number	*Description*
88999	Out of province ambulatory care
89995	Nursing home in Alberta
89996	Unclassified / unknown health institution
89997	Home care program
89998	Senior citizen's lodge
89999	Out of province or country acute care hospital

Mandatory Data Elements

Example (i): The service recipient is transferred to General Hospital Emergency Department from Sunshine Hospital Endoscopy Day/Night care. Sunshine Hospital records the General Hospital's ambulatory care number as institution to.
General Hospital Ambulatory Care # 88199

Example (ii): The service recipient is transferred to General Hospital Inpatient Unit from Regional Hospital's Cardiac Clinic. Regional Hospital records General Hospital's inpatient number as institution to.
General Hospital's Inpatient # 80199

14. Service Visit Date

(SF #420, Mandatory, Len=8. N, N/A)

The visit date is the calendar date that a service recipient receives an ambulatory care service (year, month, day). In the case of service recipients seen multiple times (e.g. therapeutic specialties), the date the service recipient is seen is the visit date.

Example (i): The service recipient was registered in the Emergency Department at 2200 hours on June 30, 2005 and was discharged at 0100 hours, July 1, 2005.
Visit date is 20050630

Example (ii): The service recipient was seen in Rehabilitation Services for treatment on consecutive days for a ten day period.
Each date the service recipient was seen is the visit date.

15. Doctor Number

(May report a maximum of 5 Doctor Numbers)
(SF#126, 141, 156, 171, 186, Mandatory, Len=15, N, LJ All trim)

The Doctor Number is the Personal Health Number (PHN) OR the region/facility assigned number of the physician responsible for the care and treatment of the service recipient at the ambulatory care service. The first Doctor Number reported should be that of the physician considered the most responsible for the care of the service recipient, and is mandatory to report when the service recipient is seen by a physician.

Reporting additional Doctor Numbers, to a maximum of four, is optional.

This field is left blank if the service recipient is not seen by a physician.

Mandatory Data Elements

Example (i): Dr. Jones repaired Mr. Doe's hernia in Day/Night care. He is the physician responsible for Mr. Doe's care. His Doctor number is 345678910.
Enter 345678910_ _ _ _ _ _

Example (ii): Mr. MacDonald was seen in the Diabetic clinic by Nurse Jones who is responsible for his diabetic education. Mr. MacDonald was not seen by a physician.
The Doctor Number is left blank

16. Provider Type

(May report a maximum of 5 Provider Types for non-mental health service recipients)
(SF #201, 206, 211, 216, 221, Mandatory, Len=5, N, N/A)

The provider type is a five digit code which identifies providers responsible for providing a clinically relevant type of service during a visit. See Provider Type numbers on the following page.

NOTE: Provider Type is mandatory to report for:

- Mental health visits
- Emergency room and day surgery visits. At minimum it is mandatory to report the main service provider. Other providers may also be reported for emergency room and day surgery visits if desired.

Provider Type is optional to report for other visits.

Reporting standards for provider type are:

1. Include all multiple providers of the same profession.
2. The same provider should be reported only once for a visit.
3. Exclude laboratory technicians.
4. Exclude clerk/secretarial support.
5. Exclude health service providers listed if they are performing a support function.
6. The provider types in italics and bolded are the required providers to be reported for mental health service recipients.
7. Up to five provider types may be reported to Alberta Health & Wellness.

Mandatory Data Elements

Valid primary and secondary provider types are:

Code	Provider Type Description	Code	Provider Type Description
03141	Audiologist	03219	Orthotist
09988*	Audiology Aide/Assistant	09999*	Other
03235	Audiology Technician	04154	Pastoral Care
03217	Cardiology Technician	03131	Pharmacist
06473	Child Care Assistant	03142	Physical Therapist
04164	Child Care Program Planning Officer	03112	***Physician***
04212	Child Care Worker	06631	Physiotherapy Aide/Assistant
04165	Child Health Care Program Planning Officer	03123	Podiatrist
03122	Chiropractor	09977*	Polysomnographic Technologist
03132	Clinical Dietitian	09982*	Prosthetic Technician
03223	Dental Technician	09983*	Prosthetist
03113	Dentist	09990*	***Psychiatrist***
09993*	Dialysis Assistant	04151	***Psychologist***
09981*	Orthotic Technician	09976*	***Psychology Assistant***
09994*	Dialysis Technician	04169	***Psychometrist***
06631	Dietary Aide	03215	Radiation Therapist/Radiological Technician
03219	Dietary Technician	03111	Radiologist
04214	Early Childhood Development Therapist	09992*	***Recreational Aide/Assistant***
03218	EEG Technician	03144	***Recreational Therapist***
03234	Emergency Medical Technician	03152	***Registered Nurse***
09995*	EMG Technician	09989*	***Registered Psychiatric Nurse***
09996*	ENG Technician	09979*	Rehabiliation Engineer Aide/Technician
09973*	Genetics Counsellor	09972*	Rehabilitation Practitioner
09974*	Independent Living Support Worker	09991*	Resident
09985*	Kenesiologist	09987*	Respiratory Aide/Assistant
03413	Licensed Practical Nurse	03214	Respiratory Technician
09997*	Medical Student	03214	Respiratory Therapist
04212	***Mental Health Therapist***	04142	School Teacher
03232	Midwife	09980*	Seating Technician
09978*	Nursing Attendant	09975*	***Social Work Assistant***
09984*	Nursing Practitioner	04152	***Social Worker***
03143	***Occupational Therapist***	03216	Sonographer
06631	***Occupational Therapy Aide/Assistant***	09986*	Speech-Language Aide/Assistant
05221	Ophthalmic Photographer	03141	Speech-Language Pathologist
03235	Ophthalmic Technician	09998*	Student (other than medical)
03414	Orthopaedic Technician	99999*	No Clinical Provider

* Additional codes created where provider type not defined in national list.

NOTE: Some occupational titles classified within the same unit group are assigned the same numbers.

Example: Respiratory Technician: 03214; Respiratory Therapist: 03214
Report this number as 03214

17. Mis Primary Code

(SF #226, Mandatory, Len=9, N, LJ All trim)

The MIS Primary code is a five to nine digit code that identifies the functional centre for which an ambulatory care service event is being reported. Valid MIS Primary codes are 7112060 (Employee Health), 713, and some 714 and 715 codes under the Alberta MIS - Primary Chart of Accounts. See Section 6 in this manual for valid MIS Primary codes.

Example (i): A service recipient attends Emergency for a sprained ankle where he is assessed by a physician and a nurse. A physical therapist is called to Emergency to provide crutch walking training.
Two ambulatory care visits are reported; one under the Emergency MIS Primary Code 71310 (for the physician/nurse services) and one under the Physiotherapy MIS Primary Code 71450 (for the physical therapist services).

Example (ii): A service recipient attends Emergency for a sprained ankle where he is assessed by a physician and a nurse. The service recipient then goes to the Physiotherapy area where a physical therapist provides crutch walking training.
Two ambulatory care visits are reported; one under the Emergency MIS Primary Code 71310 (for the physician/nurse services) and one under the Physiotherapy MIS Primary Code 71450 (for the physical therapist services).

Example (iii): A service recipient attends a Cardiac Clinic for consultation with a specialist. The Cardiac Clinic is located in the Emergency Department.
One ambulatory care visit is reported under the Cardiac Clinic MIS Primary Code 7135020.

18. Mode of Service

(SF #235, Mandatory, Len=1, N, N/A)

Mode of service is a one digit code which identifies the manner in which an ambulatory care service was provided to a service recipient. Please note that categories 1 through 7 and 9 refer to individually registered service recipients.

Mandatory Data Elements

Valid values are:

Code	Description
1	Service is face-to-face with a service recipient and a regional service provider at a regional health service site.
2	Service is face-to-face with a group of service recipients and a regional service provider at a regional health service site.
3	Telephone service with a service recipient and a regional service provider, which takes the place of face-to-face service and is worthy of clinical documentation.
4	Videoconference service with a service recipient and a regional service provider, which takes the place of a face-to-face service and is worthy of clinical documentation.
5	Service with a service recipient and a regional service provider at the service recipient's home.
6	Service with a service recipient and a regional service provider at a location out of the region.
7	Service with a service recipient and a regional service provider at a regional non-health service site (e.g. school, business setting).
8	Service is with a non-individually registered service recipient(s) and a regional service provider (Stakeholder Type 2).
9	Service is with a service recipient receiving discrete diagnostic imaging investigation. A discrete DI visit is reported when a service recipient visits an ambulatory care service area and receives diagnostic imaging services only (i.e. a "stand alone" visit for DI services only).

NOTES: An ambulatory care visit must be reported for each mode of service provided to a service recipient.

In the event that a category is not available to reflect both mode of service and location of service accurately, choose the category that reflects the location of service.

Example: *A service recipient meets face-to-face with a social worker and then receives services as part of a group.*
Two ambulatory care visits are reported; one with Mode of Service (1) recorded, and the other with Mode of Service (2) recorded.

19. Disposition

(SF #236, Mandatory, Len=1, N, N/A)

Disposition identifies the service recipient's type of separation from the ambulatory care service.

Valid values are:

Code	Description
1	Discharged - visit concluded.
2	Discharged from program or clinic - will not return for further care. (This refers only to the last visit of a service recipient discharged from a treatment program at which he/she has been seen for repeat services).
3	Left against medical advice. (Intended care not completed.)
4	Service recipient admitted as an inpatient to Critical Care Unit or OR in own facility.
5	Service recipient admitted as an inpatient to other area in own facility.
6	Service recipient transferred to another acute care facility (includes psychiatric, rehab, oncology and pediatric facilities).
7	DAA – Service recipient expired in ambulatory care service.
8	DOA – Service recipient dead on arrival to ambulatory care service.
9	Left without being seen. (Not seen by a professional service provider).

20. Diagnosis Prefix

(May report a maximum of 10)

(SF #237, 245, 253, 261, 269, 277, 285, 293, 301, 309, Mandatory, Len=1, A, N/A)

An alpha prefix of “Q” may be added to further distinguish diagnoses as questionable or query diagnoses as appropriate.

Mandatory Data Elements

21. Main Ambulatory Care Diagnosis

(SF #238, Mandatory, Len=7, A, LJ All trim)

The main ambulatory care diagnosis is reported using an ICD-10-CA code.

1. The main ambulatory care diagnosis is the diagnosis, condition, problem, or in some cases, the intervention, that is the main reason for the ambulatory care services being provided to the service recipient.
2. The main ambulatory care diagnosis is medically assigned unless a physician has not been involved with the management and care of the service recipient. In instances where the diagnosis is not medically assigned, the main ambulatory care diagnosis may be assigned by the health care provider chiefly responsible for the care and treatment of the service recipient.
3. When multiple diagnoses are considered the main reason for the ambulatory care services being provided, the main ambulatory care diagnosis is the diagnosis responsible for the greatest use of resources.

22. Secondary Diagnoses

(May report a maximum of 9)

(SF #246, 254, 262, 270, 278, 286, 294, 302, 310, Mandatory, Len=7, A, LJ All trim)

Secondary diagnoses are reported using ICD-10-CA codes.

1. Secondary diagnoses are conditions or problems that influence a service recipient's need for treatment, care, or health status and co-exist at the time of service.

2. Sequence secondary diagnoses based on their impact on the ambulatory care service being provided.

See the Diagnoses Coding Standards on page 23 for more detail on coding diagnoses.

The associated external cause of morbidity and mortality codes are mandatory to report for service recipients being treated for a newly diagnosed condition reported with a code in the S00-T98 range. Reporting external cause of morbidity and mortality codes in other instances is optional.

23. Anaesthetic Type

(SF #317, Mandatory, Len=1, N, N/A)

Anaesthetic type identifies the type of anaesthetic used for interventions.

Valid values are:

Code	Description
0	OOH intervention (used with Out of Hospital interventions)
1	General
2	Spinal
3	Epidural
4	Combined general and neuraxial (epidural or spinal)
5	Other nerve block (including intravenous regional anaesthesia, neuroleptic)
6	Monitored anaesthesia care (monitoring by an anaesthetist with or without anaesthetists giving sedation or analgesia; with or without local anaesthesia)
7	Local anaesthesia (no anaesthetist present, includes topical)
8	No anaesthetic
9	Other anaesthetic NOT monitored by an anaesthetist (includes intravenous sedation, Nitrous oxide/ Nitronox)

In the event that multiple anaesthetic types are administered during a visit, report the anaesthetic considered to be the most significant. Anasthetic types are listed below from the HIGHEST to LOWEST significance.

Description
• Combined general and neuraxial (epidural or spinal)
• General
• Epidural
• Spinal
• Other nerve block (including intravenous regional anaesthesia, neuroleptic)
• Monitored anaesthesia care (monitoring by an anaesthetist with or without anaesthetists giving sedation or analgesia; with or without local anaesthesia)
• Other anaesthetic NOT monitored by an anaesthetist (includes intravenous sedation, Nitrous oxide/ Nitronox)
• Local anaesthesia (no anaesthetist present, includes topical)
• No anaesthetic

Mandatory Data Elements

24. Main Intervention

(SF #318, Mandatory, Len=10, A, LJ All trim)

The intervention performed and considered by the provider(s) to be the most clinically significant. The valid entries must be derived from the ambulatory care or CCI list of interventions. See Sections 2 and 3 and CCI for intervention codes.

See the Intervention Coding Standards on page 34 for more details on coding interventions.

25. Other Interventions

(May report a maximum of 9)
(SF #328, 338, 348, 358, 368, 378, 388, 398, 408, Mandatory, Len=10, A, LJ All trim)

Additional intervention codes performed during a service recipient's visit. See Sections 2 and 3 and CCI for intervention codes.

See the Intervention Coding Standards on page 34 for more details on coding other interventions.

26. Intervention Attributes

(May report a maximum of 10 sets)
(Status: SF #436, 438, 440, 442, 444, 446, 448, 450, 452, 454, Mandatory as specified, Len=2, A, LJ) (Location: SF #456, 458, 460, 462, 464, 466, 468, 470, 472, 474, Mandatory as specified, Len=2 A, LJ)

(Extent: #476, 478, 480, 482, 484, 486, 488, 490, 492, 494, Mandatory as specified. Len=2, A, LJ)

The attribute codes for status, location, and extent further describe a CCI intervention code.

See Section 4 for attribute codes that are mandatory to report. Other attribute codes are optional to report at this time.

27. Out Of Hospital Indicator

(May report a maximum of 10)
(SF #496, 497, 498, 499, 500, 501, 502, 503, 504, 505, Mandatory, Len=1, A, N/A)

Out of hospital indicator identifies interventions performed during the current visit but carried out at another site.

Valid values are:

Y	The intervention was performed at a site other than the reporting institution.
blank	The intervention was performed at the reporting facility.

Example: The service recipient is being treated in ER at Hospital A for possible CVA. The service recipient is transferred to Hospital B for an MRI and then transferred back to Hospital A for additional treatment.
Hospital A reports the CCI intervention code for the MRI along with the out of hospital indicator Y.

28. Number of Previous Term Deliveries for Therapeutic Abortion Cases

(SF #577, Mandatory, Len=2, N, N/A)

The number of previous full term deliveries (37+ completed weeks gestation). Valid values include 00-20, 99 (not available) and blank (for non-therapeutic abortion visits).

Example: Service recipient having a therapeutic abortion performed had one previous term delivery.
Report 01.

Mandatory Data Elements

29. Number of Previous Pre-Term Deliveries for Therapeutic Abortion Cases

(SF #579, Mandatory, Len=2, N, N/A)

The number of previous pre-term deliveries (20-36 completed weeks gestation). Valid values include 00-20, 99 (not available) and blank (for non-therapeutic abortion visits).

Example: Service recipient having a therapeutic abortion performed had no previous pre-term deliveries.

Report 00.

30. Number of Previous Spontaneous Abortions for Therapeutic Abortion Cases

(SF #581, Mandatory, Len=2, N, N/A)

The number of previous spontaneous abortions that the service recipient has had. Valid values include 00-20, 99 (not available), and blank (for non-therapeutic abortion visits).

Example: Service recipient having a therapeutic abortion performed had one previous spontaneous abortion.

Report 01.

31. Number of Previous Therapeutic Abortions for Therapeutic Abortion Cases

(SF #583, Mandatory, Len=2, N, N/A)

The number of previous legal therapeutic abortions that the service recipient has had. Valid values include 00-20, 99 (not available), and blank (for non-therapeutic abortion visits).

Example: Service recipient having a therapeutic abortion performed had one previous therapeutic abortion.

Report 01.

32. Gestational Age for Therapeutic Abortion Cases

(SF #585, Mandatory, Len=2, N, N/A)

The gestational age, reported in weeks. Valid values include 01-25, 99 (not available), and blank (for non-therapeutic abortion visits).

Report "Date of Last Menses" when 99 is recorded for the gestational age.

Example (i): Service recipient having a therapeutic abortion performed is at 12 weeks gestational age.

Report 12

Example (ii): Gestational age for service recipient having a therapeutic abortion is unknown.

Report 99. Also report Date of Last Menses.

33. Date of Last Menses for Therapeutic Abortion Cases

(SF #587, Mandatory, Len=8, N, N/A)

If the gestational age for a service recipient having a therapeutic abortion performed is reported as 99, this data element must be reported in the YYYYMMDD format. Otherwise, completion of this data element is optional.

This field is left blank for non-therapeutic abortion visits.

Example: Service recipient having a therapeutic abortion performed had an unknown gestational age. However, it was known that the service recipient's last menses was July 20, 2005.

Report 20050720

Optional Data Elements

Optional Fields on File Layout

34. Registration Time

(SF #506. Optional, Len=4, N, N/A)

The time (in hours/minutes) that the service recipient was registered at the facility on the day the ambulatory care service was provided. The hour is to be recorded using the 24 hour clock. **Registration time is mandatory to report for emergency room and day surgery visits.**

Example : The service recipient was registered in day surgery at 1145 hours.

Enter 1145.

35. Disposition Time

(SF #510. Optional, Len=4, N, N/A)

The time (in hours/minutes) at which the service provider discharges the service recipient from the ambulatory care service. (The service recipient is now free to leave the service area.) The hour is to be recorded using the 24 hour clock. **Disposition time is mandatory to report for emergency room and day surgery visits.** Report 2359 as the disposition time only if unavailable.

NOTE: For service recipients who expire in ambulatory care services, report the disposition time as the time the service recipient is pronounced deceased. For service recipients dead on arrival to an ambulatory care service, report the disposition time as the time the service recipient was registered.

Example : The service recipient was discharged at 1515 hours.

Enter 1515.

Optional Data Elements

36. Date Visit Completed

(SF #514, Optional, Len=8, N, N/A)

The calendar date, in YYYYMMDD format, when the service recipient completed the current visit. **Date visit completed is mandatory to report for emergency room and day surgery visits.**

Example (i): The service recipient is registered in Day Surgery on June 5, 2005 and following surgery, returns home the same day.

Enter 20050605

Example (ii): The service recipient is registered in Day Surgery on June 5, 2005 at 2000 hours and returns home at 0600 hours June 6, 2005.

Enter 20050606

37. Triage Level

(SF #522, Optional, Len=1, N, N/A)

The level of triage for the service recipient for this visit. The triage level was developed by the Canadian Association of Emergency Physicians and is applicable to ONLY those service recipients seen in an Emergency Department (MIS 71310^^) or in a Community Urgent Care Centre (MIS 71513). If multiple triage levels are documented, report the initial triage level.

As of April 1st, 2004 triage level is mandatory to report for urban hospitals. As of April 1st, 2005 triage level is mandatory to report for regional hospitals.

Valid values are:

TRIAGE LEVEL	LEVEL OF ILLNESS/ACUITY
1	Resuscitation
2	Emergency
3	Urgent
4	Semi-Urgent
5	Non-Urgent
9	Unavailable

Example : The service recipient presents to Emergency with seizures. He is alert on arrival.

The triage level is 3, urgent.

Optional Data Elements

Emergency Triage and Acuity Scale

Triage Level	Level of Illness/ Acuity	Time to Physician	Usual Presentation	Sentinel Diagnosis
1	Resuscitation	Immediate	Code/Arrest Major Trauma Shock States Near Death Asthma Severe Respiratory Distress Unconscious Seizures	Traumatic Shock Pneumothorax - Traumatic/ Tension Facial Burns with Airway Compromise Severe Burns >30% TBS Overdose with Hypotension/Unconscious AAA AMI with Complications/ CHF/ Low BP Status Asthmaticus Head Injury - Major/ Unconscious Status Epilepticus

Optional Data Elements

Triage Level	Level of Illness/ Acuity	Time to Physician	Usual Presentation	Sentinel Diagnosis
2	Emergency	Minutes (<15 Min)	Head Injury with Altered Mental State	Head Injury
			Severe Trauma	Trauma, Multiple Sites Multiple Rib Fracture Neck Injury/ Spinal Cord
			Chemical Exposure - Eyes	Alkaline/ Caustic Occular Burns
			Chest Pain - Visceral (± Assoc. Symptoms)	AMI, Unstable Angina, CHF Chest Pain NOS Gastroesophageal Reflux
			Overdose (conscious)	Unspecified Drug/ Medicinal Overdose
			ABD Pain (Age >50) with Visceral Symptoms	AAA
			GI Bleed with Abnormal Vital Signs	Appendicitis Gastrointestinal Bleed/ Hypotension
			CVA with Major Deficit	CVA
			Asthma Severe (PEFR<40%)	Severe Asthma/ COPD
			Moderate/ Severe Dyspnea/ Difficulty Breathing	Croup
			Vaginal Bleeding Acute (Pain scale >5± Abn Vital Signs)	Spontaneous Abortion Ectopic Pregnancy/ Rupture
			Fever (Age ó 3 months) Temp ò 39.5	Epiglottitis, Meningitis, Sepsis
			Acute Psychotic Episode / Extreme Agitation	Acute Psychotic Episode/ Agitation
			Diabetic Hypoglycemia, Hyperglycemia	Diabetic Ketoacidosis Hypoglycemia/ Hyperglycemia
			Headache	Migraine, Renal Colic
			Keratitis	Keratitis
			Pain Scale 8 - 10/ 10	

Optional Data Elements

Triage Level	Level of Illness/ Acuity	Time to Physician	Usual Presentation	Sentinel Diagnosis
3	Urgent	<30 Min	Head Injury, Alert, Vomiting Moderate Trauma Signs of Serious Infection Mild/ Moderate Asthma (PEFR >40%) Mild/ Moderate Dyspnea Chest Pain, No Visceral Symptoms, Age >30 GI Bleed with Normal Vital Signs Vaginal Bleeding Acute, Normal Vital Signs Seizure, Alert on Arrival Acute Psychosis ± Suicidal Ideation Pain scale 8 - 10/10 with minor injuries	Head Injury Anterior Dislocated Shoulder Tibia/ Fibula Fracture Bimalleolar, Trimalleolar Ankle Fracture Pyelonephritis/ Sepsis Asthma without Status/ COPD Bronchiolitis/ Croup Pneumonia Chest Pain NOS (Msk,GI,Resp) GI Bleed, No complications Spontaneous Abortion Seizure Acute Psychosis ± Suicidal Ideation LBP/ Strain (Disc)
4	Semi-Urgent	<1 Hour	Head Injury, Alert, No Vomiting Minor Trauma ABD Pain (Acute) Headache Earache Chest Pain, No Visceral Symptoms, Age <30 Suicidal Ideation/ Depression Corneal Foreign Body Pain Scale 4 - 7	Head Injury, Alert, No vomiting Colles Fracture Ankle Sprain Appendicitis Cholecystitis Migraine Otitis Media/ Otitis External Gastroesophageal Reflux Suicidal Ideation/ Depression Corneal Foreign Body

Optional Data Elements

Triage Level	Level of Illness/ Acuity	Time to Physician	Usual Presentation	Sentinel Diagnosis
5	Non-Urgent	<2 Hours	Minor Trauma, Not Necessarily Acute Sore Throat, No Resp Symptoms Diarrhea Vomiting, Normal Mental State Menses Minor Symptoms Psychiatric complaints Pain Scale <4	LBP/ Strain URI Gastroenteritis Vomiting Disorders of Menstruation Dressing Changes/Cast Changes Symptoms/ Neurotic, personality and Non-psychotic Mental Disorders Unspecified Superficial Laceration(s)

38. Residence Name

(SF #87, Optional, Len=7, A, RJ All trim)

The service recipient's residence is identified as the name of the place of residence where the service recipient lives. A maximum of seven letters of the name of the residence may be recorded. Special circumstances are listed immediately below. Places that must be abbreviated are identified on the following page.

If the name is shorter than seven letters, right justify the entry.

All blanks and periods are to be **excluded**.
Example (i): High Level = HIGHLEV Cold Lake = COLDLAK St. Paul = _STPAUL

Apostrophes and hyphens are to be **included** as one of the seven letters in the residence name.
Example (ii): John D'Or Prairie = JOHND'O O'Chiese = O'CHIES
Ma-Me-O Beach = MA-ME-O

Street addresses, box numbers, RR, etc. are to be **excluded** from the residence name.

Non-resident of Alberta, but a resident of Canada, code the province or territory name only, right justified.

Optional Data Elements

Example (iii): Regina, Saskatchewan = _ _ _ _ _SK

Non-resident of Canada, but American resident, code as US.

Example (iv): Los Angeles, California = _ _ _ _ _US; Dallas, Texas = _ _ _ _ _ US

Non-resident of Canada, but resident of a country other than the USA, code as Other Country (OC).

Example (v): Paris, France = _ _ _ _ _ OC; London, England = _ _ _ _ _ OC

Residence Name: Abbreviations

The following names *must* be abbreviated as listed below:

Residence	Abbreviation
Beaver Lake	BEALAKE
Beaver Lake I.R.	BEALAIR
Beaver Ranch I.R.	BEARAIR
Blackfoot I.R.	BLACKIR
Brownvale/Peace River I.R.	BROPEIR
Buck Lake I.R.	BUCLAIR
Buffalo Head Prairie	BUFFHEA
Buffalo Lake	BUFFLAK
Calgary	CALG
Carcajou Settlement I.R.	CARSEIR
Chinook Valley	CHINVAL
Chipewyan I.R.	CHIPEIR
Cold Lake I.R.	COLLAIR
Driftpile River I.R.	DRIRIIR
Eden Valley I.R.	EDEVAIR
Edmonton	EDM
Fort	FT
Fort Chipewyan I.R.	FTCHIIR
Fort Saskatchewan	FTSASK
Fox Lake I.R.	FOXLAIR
Frog Lake I.R.	FROLAIR
Goodfish Lake I.R.	GOOLAIR
Grande	GR
Grande Prairie	GRPR
Hay Lake I.R.	HAYLAIR
Horse Lakes I.R.	HORLAIR
Island Lake South	ISLAKES
John D'Or Prairie I.R.	JOHD'IR
Lethbridge	LETH
Medicine Hat	MEDHAT
Rocky Mountain House	ROCKYMT
Rosedale Valley	ROSEVAL
Saddle Lake I.R.	SADLAIR
Samson I.R. 137	SAMSONI
Samson I.R. 137A	SAMSONA
Sandy Lake I.R.	SANLAIR
Springbrook	SPRINBR
Stony Plain I.R.	STONPIR
Sturgeon Lake I.R.	STULAIR
Transient/homeless	XX
Wabamun I.R.	WABAMIR
Wainwright C.F.B.	CAMPWAI

Note: I.R. means Indian Reserve, C.F.B. means Canadian Forces Base.

Optional Data Elements

The following residence locations must be abbreviated:

British Columbia	BC
Saskatchewan	SK
Manitoba	MB
Ontario	ON
Quebec	QC
New Brunswick	NB
Nova Scotia	NS
Prince Edward Island	PE
Newfoundland	NL
Northwest Territories	NT
Yukon Territory	YT
Nunavut Territory	NU
United States	US
Other Countries	OC
Unspecified Non-resident	NR

39. Doctor Type

(**May report a maximum of 5**)
(SF #523, 524, 525, 526, 527, Optional, Len=1, A, N/A)

The Doctor Type describes the role of the physicians associated with the service recipient in any capacity.

Type	Title	Definition
blank	No doctor involved	A physician was not involved in delivering this ambulatory service.
M	Main Physician Responsible	This is the attending physician most responsible for the care of the service recipient.
3	Other Responsible Doctor	A physician who has assumed responsibility for the care of the service recipient but who would not be considered the main physician responsible.
4	Consultant	A physician who is requested to provide advice and or treatment regarding the service recipient's condition.
5	Resident	A physician in training including interns.
7	Optional	As determined by the facility.
H	Hospitalist	A physician who devotes most of his/her clinical time to managing patients with whom there is no previous or ongoing relationship.

Optional Data Elements

40. Doctor Service

(May report a maximum of 5)
(SF #528, 533, 538, 543, 548, Optional, Len=5, N, N/A)

The Doctor Service reflects the level of training or the speciality of the physician. The service must always be accompanied by a doctor number; they are considered a pair and it is not appropriate to report a service without the corresponding doctor number.

DOCTOR SERVICE NUMBERS

Specialty	Service Number
Family Practitioner/General Practitioner	00001
Community Medicine / Public Health Physician	00002
Emergency Medicine	00003
Internal Medicine	00010
Clinical Immunology & Allergy	00011
Cardiology	00012
Dermatology	00013
Endocrinology & Metabolism	00014
Gastroenterology	00015
Nephrology	00016
Neurology	00017
Respirology	00018
Rheumatology	00019
Paediatrics	00020
Paediatric Immunology & Allergy	00021
Paediatric Cardiology	00022
Paediatric Dermatology	00023
Paediatric Endocrinology & Metabolism	00024
Paediatric Gastro-Enterology	00025
Paediatric Nephrology	00026
Paediatric Neurology	00027
Paediatric Respirology	00028
Paediatric Rheumatology	00029
General Surgery	00030
Cardiac Surgery	00031
Neurosurgery	00032
Orthopaedic Surgery	00034
Plastic Surgery	00035
Thoracic Surgery	00036
Vascular Surgery	00037
Cardiothoracic Surgery	00038

Optional Data Elements

Specialty	Service Number
Urology	00039
Paediatric General Surgery	00040
Paediatric Cardiac Surgery	00041
Paediatric Neurosurgery	00042
Paediatric Orthopedic Surgery	00044
Paediatric Plastic Surgery	00045
Paediatric Thoracic Surgery	00046
Paediatric Vascular Surgery	00047
Paediatric Cardiothoracic Surgery	00048
Paediatric Urology	00049
Obstetrics & Gynaecology	00050
Gynecologic Reproductive Endocrinology & Infertility	00051
Maternal-Fetal Medicine	00054
Critical Care Medicine	00055
Clinical Pharamacology	00056
Anaesthesia	00057
Paediatric Anesthesia	00058
Colorectal Surgery	00059
Otolaryngology	00060
Paediatric Otolaryngology	00061
Ophthalmology	00062
Paediatric Ophthalmology	00063
Psychiatry	00064
Paediatric Psychiatry	00065
Haematology	00066
Paediatric Haematology	00067
Physical Medicine & Rehabilitation.	00070
Geriatric Medicine	00072
General Surgical Oncology	00073
Medical Oncology	00074
Radiation Oncology	00075
Gynaecological Oncology	00076
General Pathology	00077
Medical Microbiology	00078
Diagnostic Radiology	00080
Medical Genetics	00082
Anatomical Pathology	00083
Haematological Pathology	00085
Neuropathology	00086
Nuclear Medicine	00089
Medical Biochemistry	00090
Paediatric Radiology	00092

Optional Data Elements

Specialty	Service Number
Neuroradiology	00093
Infectious Disease Specialist	00096
Neonatal-Perinatal Medicine	00097
Dentist	01001
Dental Surgeon	01002
Oral Surgeon	01003
Paediatric Oral Surgeon	01012
Paediatric Dentist	01013
Podiatrist	02001
Midwife	11004

41. Chart Number

(SF #49, Optional, Len=12, A, LJ All trim)

The chart number is the service recipient's unique identification number as assigned by the delivery organization. The field must be left justified. The field is alphanumeric and may be 12 characters in length.

Example (i): Chart Number 234567891098

Example (ii): Chart Number ABC1234_ _ _ _ _

42. Referral Source

(SF #553, Optional, Len=2, N, N/A)

The referral source identifies the type of person or agency making the referral resulting in service recipient contact being initiated with a service provider.

Valid values are:

Code	Description
00	No referral
01	Acute care facility including tertiary care and community health care facilities
02	Continuing care facility including extended care and nursing home facilities
03	Other health care service providers (funded by regional resources)
04	Home care
05	Services funded by non-regional resources (e.g. federal government, WCB)
06	Physician
07	Public health
08	Other individual/agency (e.g. private organizations)

Optional Data Elements

09	Significant other
10	Educational institution
11	Self
12	Unknown

Example (i): A service recipient is treated in emergency following a motor vehicle accident.

The Referral Source is 00.

Example (ii): A service recipient is treated in the Physical Therapy Department upon referral of her physician.

The Referral Source is 06.

43. Referred-To Agency

(SF #555, Optional, Len=1, N, N/A)

The referred-to agency identifies the type of person or agency to which a service recipient is referred to by a service provider.

Valid values are:

Code	Description
0	No referral
1	Acute care facility including tertiary care and community health care facilities
2	Continuing care facility including extended care and nursing home facilities
3	Other health care service providers (funded by regional resources)
4	Home care
5	Services funded by non-regional resources (e.g. federal government, WCB)
6	Physician
7	Public health
8	Other individual/agency (e.g. private organizations)
9	Community mental health or Psychiatric Facility

Example (i): A service recipient has been treated in emergency and is sent home. The Referred-To Agency is 0.

Example (ii): Upon completion of occupational therapy treatment, a service recipient is referred to Home Care.
The Referred-To Agency is 4

Optional Data Elements

44. Stakeholder Type

(SF #576, Optional, Len=1, N, N/A)

The Stakeholder Type identifies whether the service recipient is a person or an organization.

1 A person is a registered service recipient receiving a service for which all applicable mandatory data elements are reported.

2 An organization is a group of non-registered service recipients receiving a service for which the following applicable mandatory data elements are reported:

- Province Code
- Institution Number
- Submission Period
- Submission Number
- Submission Type
- Service Event Date
- Provider Types (mandatory for mental health service recipients)
- MIS Primary Code
- Mode of Service
- Main Ambulatory Care Diagnosis
- Secondary Diagnoses
- Main Intervention
- Other Interventions

Example (i): A registered service recipient attends a Physical Therapy clinic.

The Stakeholder Type is 1.

Example (ii): A clinical nutritionist presents a health education session at a school. The students are not registered service recipients.

The Stakeholder Type is 2.

Optional Data Elements

45. Coder Number

(SF #595, Optional, Len=2, N, N/A)

The Coder Number identifies the person responsible for completing the record reported. Coder Numbers are assigned by the facility.

Example (i): A coder, assigned the number 3, has completed the record for submission.

The Coder Number is 03.

Example (ii): A coder, assigned the number 10, has completed the record for submission.

The Coder Number is 10.

Additional Fields on File Layout
(Non-Abstracted Data Elements)

46. Record Type

(SF #1, Mandatory, Len=1, A, N/A)

The Record type identifies the type of record within the data submission. There are four valid record types: Value = H (Batch Header), Value = A (to add a record), Value = D (to delete a record), and Value = C (to change a record previously submitted).

47. Fiscal Year

(SF #7, Mandatory, Len=4, N, N/A)

Represented by the year the fiscal year concludes in. For example, the fiscal year April 1, 2005 to March 31, 2006 is represented by the year 2005.

48. Site Code

(SF #418, Optional, Len=2, A, LJ All trim)

The site code identifies the exact site where the services have been provided. This data element only applies to facilities that have different sites defined under the same institution number. This data element is user defined.

49. Service Event Number

(SF #428, Optional, Len=8, A, LJ All trim)

The service event number is used for internal facility identification of a service event.

50. Encounter Number

(SF #556, Optional, Len=20, A, LJ All trim)

The encounter number facilitates internal tracking of a service event episode and is user defined.