**Section 1010.APPENDIX C Ambulatory Surgical Data Elements**

Data elements affected by implementation of ICD-10 coding scheme October 1, 2013 (or as stipulated by CMMS) are noted when necessary and appropriate.

**Detail Data**

1. Facility identifier (Federal tax identification number/Department assigned/NPI)

2. Surgical site identifier (Department assigned)

3. Patient account number

4. Patient zip code and Plus 4

5. Patient birth date (MMDDCCYY)

6. Patient sex

7. Date (MMDDYY) and time (HH) of visit

8. Time (HH) of discharge

9. Type of admission/visit

10. Source of admission/visit

11. Patient discharge status

12. Type of bill

13. Total patient charges and components of those charges (revenue codes, HCPCS codes with modifiers, date of service, units of service and charges)

14. Primary payer ID and health plan name

15. Secondary and tertiary payer ID and health plan name (required when present)

16. Principal and secondary diagnosis codes, when present (up to 25 per data record and up to 50 with record pagination when necessary)

ICD-9 codes required: current discharges through discharges of September 30, 2013 (or last date of CMMS acceptance of ICD-9 codes)

ICD-10 codes required: discharges on and after October 1, 2013 (or first date of revised CMMS acceptance of ICD-10 codes)

17. Principal and secondary procedure codes and dates (MMDDYY), when present (up to 25 per data record and up to 50 with record pagination when necessary); only the values of the CPT coding scheme will be accepted as procedure codes for outpatient data submissions

18. Attending clinician ID number/NPI

19. Operating clinician ID number/NPI

20. Other clinician ID number/NPI (up to 2 required when present)

21. Patient race (according to OMB guidelines)

22. Patient ethnicity (according to OMB guidelines)

23. External cause of injury codes (required when present)

ICD-9 Ecodes: three required if available: current discharges through discharges of September 30, 2013 (or last date of CMMS acceptance of ICD-9 codes)

ICD-10 Ecodes: eight required if available: discharges on and after October 1, 2013 (or first date of CMMS acceptance of ICD-10 codes)

24. Patient county code (5 digits: state and county codes for Illinois and border state residents (FIPS code))

25. Patient reason for visit (diagnosis codes up to three required when present)

26. Accident state abbreviation (required when present)

27. Condition employment related (required when present)

28. Accident employment related occurrence code and date of accident (required when present)

29. Crime victim occurrence code and date of crime (required when present)

30. Page number and total number of pages of this claim

31. Insurance group number (up to three required when present)

32. Diagnoses code version qualifier

ICD-9 indicator required = 9: current discharges through discharges of September 30, 2013 (or last date of CMMS acceptance of ICD-9 codes)

ICD-10 indicator required = 0: discharges on and after October 1, 2013 (or first date of CMMS acceptance of ICD-10 codes)

33. Statement covers period (from and through [discharge date] dates)

34. Patient name (first, middle, last, suffix)

35. Patient address (PO Box or street address, apartment number, city and state)

36. Unique patient identifier based on the last four digits of patient Social Security number

37. Primary insured's unique identifier (beneficiary/policy #)

38. Any element or service adopted for use by the National Uniform Billing Committee pursuant to Section 4-2(d)(14) of the Act. Elements or services would be added as a submission requirement accompanied by sufficient notification to all submitting facilities and health care systems. Notice would be provided no less than 90 days in advance of the submission requirement.

(Source: Amended at 36 Ill. Reg. 8017, effective May 8, 2012)