

**Department of State Health Services
Council Agenda Memo for State Health Services Council
February 24, 2011**

Agenda Item Title: Amendments to rules concerning the collection and release of outpatient surgical and radiological procedures at hospitals and ambulatory surgical centers

Agenda Number: 4.a.viii

Recommended Council Action:

For Discussion Only

For Discussion and Action by the Council

Background: The Texas Health Care Information Collection program (THCIC) is housed in the Health and Information and Vital Statistics Section, Center for Health Statistics, within the Chief Operating Officer's Division.

THCIC has been collecting inpatient discharge data since 1999 and outpatient surgical and radiological procedure data from hospitals and ambulatory surgery centers (ASCs) since October 2009. The data are used for analysis of health care quality and utilization. DSHS uses the data for the creation of Public Use Data files and Research Data files for use by other DSHS programs, such as the Cancer Registry and Birth Defects Registry, and by other health care researchers, other state agencies and state universities.

THCIC collects administrative health care claims data from approximately 1000 healthcare facilities, (approximately 620 hospitals and approximately 380 ASCs) through a contracted vendor. THCIC also collects a limited Healthcare Effectiveness Data and Information Set from Health Maintenance Organizations (approximately 36 Service Areas from 9 health plans).

The annual program budget is approximately \$1.49 million of which the vendor contract is approximately \$950,000 per year from General Revenue (~\$1.19 million/yr) and Data Sales (~ \$300,000/yr).

Key Health Measures: The rules establish the outpatient reporting requirements for hospitals and ASCs and the requirements for re-release of data collected by DSHS data from those facilities.

- The amendments will provide hospitals and ASCs with better information regarding which specific patients' data are to be submitted to DSHS. The amendments clarify which procedures are required to be submitted and this will reduce submission of extraneous data by facilities.
- After the rules become effective, a review of data submission records will determine whether facilities are submitting the required outpatient data.
- A review of correspondence with facilities from a helpdesk documentation tracking system will determine whether there is a reduction in volume and the type of questions being asked.
- THCIC will track requests from DSHS programs, other state agencies, universities, and other researchers for public use and research data files.
- THCIC will also track access of reports developed from the data on the program website.

Summary: The amendments for collecting and reporting outpatient data will provide the public with standardized data, reports and information regarding the type of surgical services or radiological services, volume, average charges, and complexity of patient services provided by the hospitals or ASCs. The data may assist the consumer in making informed decisions on health care issues regarding quality of care being provided by hospital outpatient surgical services and ASCs.

The proposed amendments are necessary to clarify the scope of the data to be reported to DSHS. The proposed amendments:

- clarify that “Event Claims” submitted to DSHS are not available to the public and shall not be released by DSHS;
- establish a list of Service and Procedure Categories, which correspond to the Agency for Healthcare Research and Quality Service and Procedure Categories, defining the data reporting requirements;
- add revenue code 0320 (Radiology -- Diagnostic General Classification) to the list of revenue codes; and
- establish a requirement for DSHS to place a listing of the procedure codes covered by the categories on its website on or before September 1 of the year prior to data collection.

Amendment to rules adopted in November 2008 required providers to submit data using revenue codes since these codes change less often than procedure codes; however, several issues regarding the use of the revenue codes have come to the attention of DSHS since reporting began in October 2009.

- ASCs that submit claims to the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), are required to submit claims in the American National Standards Institute, Accredited Standards Committee X12N, 837 Health Care Professional Claim Implementation Guide (ANSI 837 Professional) format, which does not contain a revenue code field in the electronic claim format structure required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CMS adopted the rule referencing the ANSI 837 Professional while amendments to 25 TAC, Section 421.68(a) were being vetted through the rule review process.
- DSHS Legal Counsel recommended that the rules be amended since the ANSI 837 Professional format does not include revenue codes. ASCs that use that format for billing have no way of determining the data to submit to DSHS.
- Several facilities expressed confusion and uncertainty to DSHS regarding the revenue codes.
- Revenue codes have a many-to-many relationship with surgical and radiological procedure codes; and therefore, some procedure codes may be included in other revenue codes that are not part of the required list in Section 421.67(f), potentially resulting in some outpatient data not being submitted.

The proposed Service and Procedure Categories are more stable than procedure codes and will require fewer amendments to the rules. The related Healthcare Common Procedure Coding System (HCPCS) codes change quarterly. A list of HCPCS codes included in the proposed Service and Procedure Categories will be updated annually and posted on the DSHS’s website. Facilities can use this list to determine the data required to be submitted to DSHS.

The new data elements cannot be required to be submitted to DSHS before the 90th day after the date the rules are adopted and must take effect no later than the first anniversary after the date the rules are adopted.

Summary of Input from Stakeholder Groups: Stakeholder meetings were held on September 16, 2010 and October 21, 2010.

The meeting notices were posted on the THCIC website and the following groups were contacted by e-mail: Texas Senate Health and Human Services Committee; Texas Health and Human Services Commission; Governor’s Office; DSHS Council members; Texas Hospital Association; Texas Ambulatory Surgery Center Society; Dallas-Fort Worth Hospital Council; Texas Medical Association; Texas Association of Businesses; Consumer’s Union; Memorial Hermann Hospital System; East Texas Medical Center; Texas Health Resources, Inc.; Austin Radiological Association; Blue Cross Blue Shield of Texas; Texas Tech Health Science Center School of Nursing; Hospital Corporation of America; QuadraMed, Inc.; and Hillco Partners, Inc.

The stakeholders have agreed with the addition of Service and Procedure Categories.

The stakeholders recommended that the revenue codes be retained in the rules because some facilities extract their data for submission to DSHS by revenue code and changes to many of their systems would have an estimated minimum cost of \$10,000 annually.

The draft amendments to the rules were modified to retain the revenue code list, including adding the “0320 (Radiology -- Diagnostic General Classification)” and adjust the numbering to include the Service and Procedure Categories.

There were no unresolved issues after meetings with the stakeholders.

Proposed Motion:

Motion to recommend HHSC approval for publication of rules contained in agenda item #4.a.viii

Approved by Assistant Commissioner/Director: Ramdas Menon, Ph.D. **Date:** 1/26/2011

Presenter: Bruce Burns, D.C. **Program:** Texas Health Care Information Collection **Phone No.:** 6431

Approved by CCEA: Carolyn Bivens **Date:** 2/01/2011

Title 25. Health Services
Part 1. Department Of State Health Services
Chapter 421. Health Care Information
Subchapter D. Collection And Release Of Outpatient Surgical And Radiological Procedures At Hospitals And Ambulatory Surgical Centers
Amendments §§421.61, 421.62, 421.66 - 421.68

Proposed Preamble

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes amendments to §§421.61, 421.62, and 421.66 - 421.68 concerning the collection and release of data relating to individual patients which have had surgical procedures or radiological procedures performed in Texas hospitals (as an outpatient service including in the emergency department) or ambulatory surgical centers.

BACKGROUND AND PURPOSE

Sections 421.61 - 421.68 relate to the collection and release of outpatient surgical and radiological procedures at hospitals and ambulatory surgical centers. The department began collecting data on outpatient services at hospitals and ambulatory surgery centers in October 2009. The rules were originally developed and adopted by the Texas Health Care Information Council (council) and were transferred to the department on September 1, 2004, as a result of the consolidation of health and human services agencies under House Bill 2292 (HB 2292), 78th Texas Legislature, 2003, and then were amended to comply with Sections 2 and 3 of Senate Bill 1731 (SB 1731), 80th Texas Legislature, 2007, which amended the Health and Safety Code, Chapter 108.

Health and Safety Code, Chapter 108, requires the Executive Commissioner to adopt rules to implement the collection and release of data from health care facilities. The proposed amendments are necessary to clarify the scope of the data to be reported to the department regarding which outpatients receiving surgical or radiological services. Several facilities and contract vendors have contacted department staff regarding which patient data they are required to submit. Many of the questions involved the revenue codes that are listed in §421.67(f). For example “Do we send only those charges for the revenue codes listed in the rules?” or “Some of the payers do not require revenue codes, so we do not put them on the claim, do we need to send that data?” One data submitter asked why revenue code 0320 (Radiology -- Diagnostic General Classification) was not included in the specified revenue code list in the rules, this code has been added to the list in §421.67(f). A stakeholder meeting was held on September 16, 2010 and two of the stakeholders recommended that the department retain the requirement of submitting outpatient data by revenue codes, since many hospitals select and extract their data according to the revenue codes. The stakeholders recommended that the department add the option to report by the Service and Procedure Categories as an alternative to the revenue code requirement.

Health and Safety Code, §108.009, requires providers to submit data as required by these sections. The Health Insurance Portability and Accountability Act (HIPAA) privacy regulations at 45 Code of Federal Regulations, §164.512(a), allow health care providers to disclose protected health information without a patient’s consent or authorization when disclosure is required by

law. Since state law requires disclosure to the department, the HIPAA regulations allow the submission of the data.

The new data elements cannot be required to be submitted to the department before the 90th day after the date the rules are adopted and must take effect not later than the first anniversary after the date the rules are adopted.

Government Code, §2001.039, requires that each state agency review and consider for readopting each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Sections 421.61 - 421.68 have been reviewed and the department has determined that reasons for adopting the sections continue to exist because rules on this subject are needed. However, §§421.63, 421.64, and 421.65 are not being changed at this time.

SECTION-BY-SECTION SUMMARY

The phrase “or surgical and radiological categories” is inserted after “revenue codes” and the reference is updated to include “or §421.67(g) in the following proposed sections: §421.61 - Definitions, paragraph (10) - Certification File and paragraph (38) - Outpatient or patient; §421.62(a) and (b); and §421.66(c)(3).

Section 421.61 is amended by adding definitions for “Radiological Procedures” and “Surgical Procedures” for the purposes of this subchapter. The terms are added to clarify which procedures performed on patients within the facility are required to have the required data elements submitted to the department.

Sections 421.61(b), 421.62(g), 421.66(g) and 421.68(j) contain the implementation date of July 1, 2009, which is no longer appropriate, and are being deleted.

Section 421.67(d) is amended by adding paragraph (33), “Service Line Date (effective 90 calendar days after being published in the *Texas Register*)” to the required minimum data set and renumbers the list of required data elements for facilities that provide one or more of the services that are included under the revenue codes specified in subsection (f) of this section for patients which are uninsured, considered as self pay, or are covered by a third-party payer which requires the facility to submit a claim in an ANSI 837 Institutional Guide format or CMS-1450 format. Subsection (f) is amended by adding revenue code “0320 Radiology--Diagnostic General Classification (effective 90 calendar days after being published in the *Texas Register*)” in paragraph (1), which was previously omitted inadvertently, and the other revenue codes are renumbered. Language is added to provide an option for identifying the required outpatients data which should be submitted to the department. New subsection (g) establishes a listing of the Service and Procedure Categories and adds language which requires the department to publish on the department website a list of the Healthcare Common Procedural Code Set (HCPCS) codes relating to the categories by September 1 of the year before the data is to be submitted. The HCPCS codes are a list of procedure codes which cover many surgical and radiological procedures of outpatients that are high cost or high in volume whose data shall be submitted to the department in compliance with this subchapter. Subsection (g) is renumbered as subsection (h) of this section and contains a new implementation date of September 1, 2011.

Section 421.68(a) provides additional privacy and confidentiality protection for patients and physicians and states that event claims in any format submitted to the department are not available to the public and are exempt from disclosure and shall not be released.

FISCAL NOTE

Ramdas Menon, Ph.D., Director, Center for Health Statistics, has determined that for each calendar year of the first five years that the sections are in effect, there will be no fiscal implications to the state as a result of enforcing or administering the sections as proposed. The effect on state government will have no anticipated additional cost to the department, because of the addition of the Service Line Date data element in the §421.67(d) and the addition of revenue code “0320 Radiology--Diagnostic General Classification” and the addition of new subsection (g) which establishes the Services and Procedure category code list for facilities to identify which procedures they should submit to the department and requires the department to update the HCPCS codes yearly. The department’s contractor will modify the system each year to filter out the patients based on the list of HCPCS codes from the list determined and published by department staff. The State Hospitals and Texas Center for Infectious Diseases indicated that they would not incur any additional costs to comply with the proposed amendments. The other state facilities provided no estimate of costs.

The fiscal implications of submitting the data with the additional service line date for the surgical procedures or radiological procedures covered by the specified revenue codes in §421.67(f) or the service and procedure categories listed in new subsection (g) of this section for local governments that own or operate hospitals or ambulatory surgical centers will vary. The costs are dependent on whether they already submit service line date on their data and on the complexity of the hospital’s or ambulatory surgery center’s information technology, or their contract requirements with any vendors involved in their information systems process. The facilities that submit all their outpatient data, would incur no additional costs. The department’s contract vendors system would filter out the claims that do not have the appropriate revenue codes or the appropriate procedure codes, those records would not be entered into the system. Two of nine local government entities responded that they would incur no additional costs. The department estimates that costs for local government entities may range from no additional costs up to a similar one-time a year cost of \$31.36 (\$15.68 X approximately 2 hours) for first year costs with approximately \$33, \$34, \$35, \$37 and \$38 per subsequent year on personnel costs, to identify which of the facilities procedures they perform are on the published procedure list.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS AND ECONOMIC IMPACT TO PERSONS

Dr. Menon anticipates that those hospitals or ambulatory surgical centers which are required to report under Health and Safety Code, Chapter 108, and these sections may or may not incur costs dependent upon the complexity of their information technology systems or their data submission process (some facilities submit all their outpatient data, therefore, would incur no additional costs). Hospitals and ambulatory surgical centers that create a separate data claim for the department that is different from their billing systems, or do not submit data electronically, will incur additional costs dependent on the complexity of their information technology system.

Facilities that continue to sort out data by revenue codes may incur a small cost (dependent upon their system design) in updating their system to include the 0320 revenue code and the “service line date” data element if it is not already submitted. Facilities that choose to sort out the data by HCPCS codes will incur costs dependent on their ability to select the HCPCS code ranges published on the department website each year. Facilities that submit all outpatient data will incur no additional costs as a result of the proposed amendments. Rural hospitals are exempt from reporting; therefore, rural hospitals that might qualify as a small business or micro-business are not included in this analysis.

The department estimates that the number of hospitals and ambulatory surgical centers (ASC) that are small businesses (for-profit, independently owned, and under 100 employees or under \$6 million in annual gross receipts) is approximately 110. The department is not aware of any hospitals (not including rural hospitals) that are micro-businesses (for-profit, independently owned, and under 20 employees). The department believes that the number of ambulatory surgical centers that are small businesses or micro-businesses is approximately 300, of which 200 are estimated to be micro-businesses.

Dr. Menon anticipates that hospitals and ambulatory surgical centers that are required to submit data will either submit all outpatient data or will modify their computer systems to sort, capture and submit the required data according to the rules and the proposed amendments. The hospitals and ambulatory surgical centers that are small businesses or micro-businesses that contract with a vendor or have built a computer system that is separate from their billing system may incur varying costs if they choose to modify their system to extract only the patients that have surgical or radiological procedures performed in their facilities. The costs depend upon the complexity of their systems and contract requirements with any vendors involved with the hospitals’ or ambulatory surgical centers’ information technology systems for sorting and submitting the data.

Cost estimates were requested and obtained for: (a) Licensed hospitals and ambulatory surgical centers were contacted; (b) Several ambulatory surgical centers, which are small businesses or micro-businesses. Based on this information, the department estimates that the economic impact of the sections on hospitals and ambulatory surgical centers that are small businesses or micro-businesses will range from no additional costs to an estimated one-time a year identification of the procedures performed in their facility that match to the procedure codes published by the department on their website \$31.36 (\$15.68 X approximately 2 hours) for first year costs, with approximately \$33, \$34, \$35, \$37 and \$38 per subsequent year on personnel costs.

The department considered alternative methods of achieving the purposes of the proposed sections. The purposes of the sections could be broadly stated as enhancing the ability of the state and the department to collect data for analysis to assist the public in making informed choices when selecting a hospital or ambulatory surgical center for services. One alternative could be to not change the required revenue code list to surgical and radiological procedure categories and not require the collection of “Service Line Date,” as proposed by these sections; in other words, not propose or adopt any new sections or amendments to these sections. Under that alternative, the department would continue to collect the inpatient hospital data and outpatient data that it currently collects. While this alternative would provide the public with the current data to help the public make choices, it would not provide clear instruction to the providers on which outpatients’ data are required to be submitted to the department and the data

reported by the department would not be accurately reported to the public, therefore the department would not be able to accurately enforce the rules for compliance. This alternative was not accepted.

Another alternative could be to collect all hospital outpatient data and ambulatory surgical center outpatient data. While this alternative would provide the public with the best set of data to help the public make choices and clear language to the providers regarding which patients' data to submit to the department, it is not fiscally feasible. This alternative, which is authorized by Health and Safety Code, Chapter 108, would require the department to collect and process over 30,000,000 outpatient records a year versus the estimated 3,200,000 outpatients that receive surgical or radiological procedures and would increase the contracted costs beyond the Texas Legislature appropriated funds for additional data collection, estimated to be sufficient for the outpatient data collection and analysis. This alternative was not accepted.

A third alternative could be to propose specific surgical and radiological procedure codes and collect data based on those codes, rather than revenue codes. In meetings and discussions with stakeholders representing hospitals and ambulatory surgical centers, the stakeholders requested the department to use revenue codes because of the relative stability of procedure codes and require fewer rule amendments and information system changes. Use of either type of codes would meet the purposes of these sections. The alternative of using procedures codes was not accepted because of the stated preference of the stakeholders.

The anticipated economic costs to persons (hospitals or ambulatory surgical centers that are required to report under Health and Safety Code, Chapter 108) who are required to comply with the sections as proposed will be dependent upon the complexity and status of their information systems and will range from no additional costs to an estimated \$31.36 (\$15.68 X approximately 2 hours) for the first year. The annual costs thereafter would range from zero to approximately \$33, \$34, \$35, \$37 and \$38 per subsequent year on personnel costs.

There will be little effect on local employment. The department assumes that any person hired would be hired in the first year that the rules are in effect. No additional local employment is anticipated in the subsequent years.

PUBLIC BENEFIT

Dr. Menon has also determined that for each year of the first five years the sections are in effect, the public will benefit from the adoption of the amended sections. The public benefit anticipated as a result of collecting and reporting of this data is the ability to provide the public with data and information regarding the type of surgical services or radiological services, volume, average charges, and the complexity of patient services provided by the hospitals or ambulatory surgical centers. The public will benefit from health care provider reports and information about the quality of care being provided by hospital outpatient surgical services and ambulatory surgical centers. The standardized data and the reports and information developed by the department from the data will assist the consumer in making informed decisions on healthcare issues.

REGULATORY ANALYSIS

The department has determined that the proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. The proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposed rules do not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, do not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted to Bruce M. Burns, D.C., Center for Health Statistics, Department of State Health Services, Mail Code 1898, P.O. Box 149347, Austin, Texas 78714-9347, Fax (512) 458-7740. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register*.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The amendments are authorized by Health and Safety Code, §§108.006, 108.009, 108.010, 108.011 and 108.013, which require the Executive Commissioner to adopt rules necessary to carry out Chapter 108 including rules on data collection requirements, to prescribe the process of data submission, to implement a methodology to collect and disseminate data reflecting provider quality, to specify data elements to be required for submission to the department and which data elements are to be released in a outpatient event public use data file; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the rules implements Government Code, §2001.039.

The amendments affect the Health and Safety Code, Chapters 108 and 1001; and Government Code, Chapter 531.

Legend: (Proposed Amendment(s))

Single Underline = Proposed new language

[Bold Print, and Brackets] = Current language proposed for deletion

Regular Print = Current language

(No change.) = No changes are being considered for the designated subdivision

§421.61. Definitions.

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

(1) - (9) (No change.)

(10) Certification File--One or more electronic files (may include reports concerning the data and its compilation process) compiled by DSHS that contain one record for each patient event which has at least one procedure covered in the revenue codes or surgical and radiological categories specified in §421.67(f) or §421.67(g) of this title (relating to Event Files--Records, Data Fields and Codes) submitted for each facility under this subchapter during the reporting quarter and may contain one record for any patient event occurring during one prior reporting quarter for whom additional event claims have been received.

(11) - (37) (No change.)

(38) Outpatient or patient--For the purposes of this subchapter a patient who receives surgical or radiological services from an ambulatory surgical center or a patient who receives surgical or radiological services from a hospital and is not admitted to a hospital for inpatient services. Outpatients include patients who receive one or more services covered by the revenue codes or surgical and radiological categories that are specified in §421.67(f) or §421.67(g) of this title, which may occur in the emergency department, ambulatory care, radiological, imaging or other types of hospital units. Outpatient includes a patient who is transferred from an ambulatory surgical center to another facility or a hospital patient who is under observation and not admitted to the hospital.

(39) - (43) (No change.)

(44) Radiological procedures - For the purposes of this subchapter, diagnostic procedures performed on a patient using radiant energy devices (Projection Radiology (for example - X-ray), Computed Tomography, or other ionizing radiation) or diagnostic radioactive material or other non-ionizing imaging devices (e.g., Magnetic Resonance Imaging, Nuclear Medicine devices (for example Positron Emission Tomography), Sound Imaging devices (for example Ultrasound or Echocardiography), Thermal imaging devices, Diagnostic Light imaging devices (for example – diagnostic photography, endoscopy, and fundoscopy) and other diagnostic imaging devices.

(45) ~~[(44)]~~ Rendering provider or rendering other health professional--For the purposes of reporting on the modified ANSI 837 Professional Guide, the physician or other

health professional who performed the surgical or radiological procedure on the patient for the event. In the case where a substitute provider (locum tenans) is used, that physician or other health professional shall be submitted as specified in this subchapter. For purposes of this definition, the term "provider" is not limited to only a physician, or facility as defined in paragraphs (27), (37) and (41) of this subsection.

(46) [(45)] Required minimum data set--The list of data elements for which facilities may submit an event claim for each patient event occurring in the facility. The required minimum data sets are specified in §421.67(d) and (e) of this title. This list does not include all the data elements that are required by the modified ANSI 837 Institutional Guide or modified ANSI 837 Professional Guide to submit an acceptable event file. For example: Interchange Control Headers and Trailers, Functional Group Headers and Trailers, Transaction Set Headers and Trailers and Qualifying Codes (which identify or qualify subsequent data elements).

(47) [(46)] Research data file--A customized data file, which may include the data elements in the public use file and may include data elements other than the required minimum data set submitted to DSHS, except those data elements that could reasonably identify a patient or physician.

(48) [(47)] Submission--The transfer of a set of computer records as specified in §421.67 of this title that constitutes the event file for one or more reporting hospitals under this subchapter.

(49) [(48)] Submitter--The person or organization, which physically prepares an event file for one or more facilities and submits them under this subchapter. A submitter may be a facility or an agent designated by a facility or its owner.

(50) Surgical procedure--For the purposes of this subchapter, an invasive procedure that penetrates or breaks the skin or other patient tissue (in vivo) for the purpose diagnosing, evaluating, analyzing, monitoring or treating a patient.

(51) [(49)] THCIC Identification Number--A string of 6 characters assigned by DSHS to identify facilities for reporting and tracking purposes. For a facility operating multiple facility locations under one license number and duplicating services at those locations, the department will assign a distinguishable identifier for each separate facility location under one license number. The relationship of the identifier to the name and license number of the facility is public information.

(52) [(50)] Uniform patient identifier--A unique identifier assigned by DSHS to an individual patient and composed of numeric, alpha, or alphanumeric characters, which remains constant across facilities and patient events. The relationship of the identifier to the patient-specific data elements used to assign it is confidential.

(53) [(51)] Uniform physician identifier--A unique identifier assigned by DSHS to a physician or other health professional who is reported as operating, rendering or other provider providing health care services or treating a patient in a facility and which remains constant across

facilities. The relationship of the identifier to the physician-specific data elements used to assign it is confidential. The uniform physician identifier shall consist of alphanumeric characters.

(54) [(52)] Validation--The process by which a provider verifies the accuracy and completeness of data and corrects any errors identified before certification.

[(b) This section is effective 90 calendar days after being published in the *Texas Register*. The department will not implement or enforce this section until July 1, 2009, at the earliest.]

§421.62. Collection of Hospital Outpatient and Ambulatory Surgical Center Data.

(a) Each facility in operation for all or any of the reporting periods described in §421.63 of this title (relating to Schedule for Filing Event Files) shall submit to DSHS event claims as specified in §421.67 of this title (relating to Event Files--Records, Data Fields and Codes) on all patient events in which the patient received one or more of the surgical procedures or radiological services covered by the revenue codes or surgical and radiological categories specified in §421.67(f) or §421.67(g) of this title. All facilities that are exempt under the Health and Safety Code, §108.0025, but choose to participate in reporting under this subchapter, shall comply with the requirements in this subchapter. To the extent the medical screening examination, triage, observation, diagnosis or treatment is made by a health professional, other than a physician, data elements specified in §421.67(d)(25) - (30) or (e)(19) of this title shall be filled accordingly or data elements in §421.67(d)(26) or (29) in the modified ANSI 837 Institutional Guide or §421.67(e)(20) in the modified ANSI 837 Professional Guide shall be marked with one of DSHS approved temporary "Physician" or "Other health professional" code numbers and data elements in §421.67(d)(25)(A) - (C) or (28)(A) - (C) in the ANSI 837 Institutional Guide format or §421.67(e)(19)(A) - (C) in the ANSI 837 Professional Guide format may be left blank.

(b) All patient events in which the patient received one or more of the surgical procedures or radiological services covered by the revenue codes or surgical and radiological categories specified in §421.67(f) or §421.67(g) of this title shall be reported by the facility that prepares one or more bills for patient services. The facility shall submit an event claim corresponding to each bill containing the data elements required by §421.67 of this title. For all patients who received one or more of the surgical procedures or radiological services covered by the revenue codes or surgical and radiological categories [**revenue codes**] specified in §421.67(f) or §421.67(g) of this title for which the facility does not prepare a bill for patient services, the facility shall submit an event claim containing the required minimum data set.

(c) - (f) (No change.)

[(g) This section is effective 90 calendar days after being published in the *Texas Register*. The department will not implement or enforce this section until July 1, 2009, at the earliest.]

§421.66. Certification of Compiled Event Data.

(a) - (b) (No change.)

(c) The signed certification form shall represent that:

(1) - (2) (No change.)

(3) to the best of their knowledge and belief, the data submitted accurately represents the facility's administrative status of patients for which the services covered by the revenue codes or surgical and radiological categories identified in §421.67(f) or §421.67(g) of this title (relating to Event File--Records, Data Fields and Codes) were provided for the reporting quarter; and

(4) - (5) (No change.)

(d) - (f) (No change.)

[(g) This section is effective 90 calendar days after being published in the *Texas Register*. The department will not implement or enforce this section until July 1, 2009, at the earliest.]

§421.67. Event Files--Records, Data Fields and Codes.

(a) - (c) (No change.)

(d) Facilities shall submit the required minimum data set in the following modified ANSI 837 Institutional Guide format for all patients that are uninsured or considered self-pay or covered by third party payers in which the payer requires the claim be submitted in an ANSI 837 Institutional Guide format or CMS-1450 format for which an event claim is required by this subchapter. The required minimum data set for the modified (as specified in subsection (c) of this section) ANSI 837 Institutional Guide format includes the following data elements as listed in this subsection:

(1) - (32) (No change.)

(33) Service Line Date (effective 90 calendar days after being published in the *Texas Register*);

(34) [(33)] Service Provider Name;

(35) [(34)] Service Provider Primary Identifier - Provider Federal Tax ID (EIN) or National Provider Identifier;

(36) [(35)] Service Provider Address:

- (A) Service Provider Address Line 1;
- (B) Service Provider Address Line 2 (if applicable);
- (C) Service Provider City;
- (D) Service Provider State; and
- (E) Service Provider ZIP; and

(37) [(36)] Service Provider Secondary Identifier - THCIC 6-digit facility ID assigned to each facility.

(e) (No change.)

(f) Facilities shall submit the required minimum data set to DSHS for each patient who has one or more **of the following revenue codes in this subsection or one or more of the outpatient surgical or radiological procedures (which are covered by the service and procedure categories listed in subsection (g) of this section)** for services rendered to the patient in the facility. Facilities operating in the State of Texas shall submit the required data elements as specified in subsection (d) or (e) of this section relating to the revenue codes in this subsection or the procedure codes covered in the service and procedure categories listed in subsection (g) of this section.

(1) 0320 Radiology--Diagnostic General Classification. (effective 90 calendar days after being published in the *Texas Register*);

(2) [(1)] 0321 Radiology--Diagnostic Angiocardiology;

(3) [(2)] 0322 Radiology--Diagnostic Arthrography;

(4) [(3)] 0323 Radiology--Diagnostic Arteriography;

(5) [(4)] 0329 Radiology--Diagnostic Other Radiology - Diagnostic;

(6) [(5)] 0330 Radiology--Therapeutic General Classification;

(7) [(6)] 0333 Radiology--Therapeutic Radiation Therapy;

(8) [(7)] 0339 Radiology--Therapeutic Other Radiology - Therapeutic;

(9) [(8)] 0340 Nuclear Medicine General Classification;

(10) [(9)] 0341 Nuclear Medicine Diagnostic;

(11) [(10)] 0342 Nuclear Medicine Therapeutic;

- (12) [(11)] 0343 Nuclear Medicine Diagnostic Pharmaceuticals;
- (13) [(12)] 0344 Nuclear Medicine Therapeutic Pharmaceuticals;
- (14) [(13)] 0349 Nuclear Medicine Other Nuclear Medicine;
- (15) [(14)] 0350 Computed Tomography (CT) Scan General Classification;
- (16) [(15)] 0351 Computed Tomography (CT)--Head Scan;
- (17) [(16)] 0352 Computed Tomography (CT)--Body Scan;
- (18) [(17)] 0359 Computed Tomography (CT)--Other;
- (19) [(18)] 0360 Operating Room Services General Classification;
- (20) [(19)] 0361 Operating Room Services Minor Surgery;
- (21) [(20)] 0369 Operating Room Services Other Operating Room Services;
- (22) [(21)] 0400 Other Imaging Services General Classification;
- (23) [(22)] 0401 Other Imaging Services Diagnostic Mammography;
- (24) [(23)] 0403 Other Imaging Services Screening Mammography;
- (25) [(24)] 0404 Other Imaging Services Positron Emission Tomography (PET);
- (26) [(25)] 0409 Other Imaging Services Other Imaging Services;
- (27) [(26)] 0481 Cardiology Cardiac Catheterization Lab;
- (28) [(27)] 0483 Cardiology Echocardiology;
- (29) [(28)] 0489 Cardiology Other Cardiology Services;
- (30) [(29)] 0490 Ambulatory Surgical Care General Classification;
- (31) [(30)] 0499 Ambulatory Surgical Care Other Ambulatory Surgical;
- (32) [(31)] 0500 Outpatient Services General Classification;
- (33) [(32)] 0509 Outpatient Services Other Outpatient;
- (34) [(33)] 0610 Magnetic Resonance Technology General Classification;

(35) [(34)] 0611 Magnetic Resonance Technology Magnetic Resonance Imaging (MRI)--Brain/Brainstem;

(36) [(35)] 0612 Magnetic Resonance Technology Magnetic Resonance Imaging (MRI)--Spinal Cord/Spine;

(37) [(36)] 0614 Magnetic Resonance Technology Magnetic Resonance Imaging (MRI)--Other;

(38) [(37)] 0615 Magnetic Resonance Technology Magnetic Resonance Angiography (MRA)--Head and Neck;

(39) [(38)] 0616 Magnetic Resonance Technology Magnetic Resonance Angiography (MRA)--Lower Extremities;

(40) [(39)] 0618 Magnetic Resonance Technology Magnetic Resonance Angiography (MRA)--Other;

(41) [(40)] 0619 Magnetic Resonance Technology Other Magnetic Resonance Technology;

(42) [(41)] 0760 Specialty Room--Treatment/Observation Room General Classification;

(43) [(42)] 0761 Specialty Room--Treatment Room;

(44) [(43)] 0762 Specialty Room--Observation Room; and

(45) [(44)] 0769 Specialty Room--Other Specialty Room.

(g) Service and Procedure Categories. The HCPCS code ranges relating to the surgical and radiological or imaging categories to be reported shall be specified by the department and published on the department website by September 1st of the year prior to the date on which the services are performed.

(1) Incision or excision of Central Nervous System (CNS);

(2) Insertion, replacement, or removal of extracranial ventricular shunt;

(3) Laminectomy, excision intervertebral disc;

(4) Diagnostic spinal tap;

(5) Insertion of catheter or spinal stimulator and injection into spinal canal;

- (6) Decompression of peripheral nerves;
- (7) Other diagnostic nervous system procedures (requiring surgical or radiological procedures);
- (8) Other operating room therapeutic nervous system surgical procedures;
- (9) Thyroidectomy, partial or complete;
- (10) Diagnostic endocrine procedures (requiring surgical or radiological procedures);
- (11) Other therapeutic endocrine procedures (requiring surgical or radiological procedures);
- (12) Corneal transplant;
- (13) Glaucoma procedures (requiring surgical or radiological procedures);
- (14) Lens and cataract procedures (requiring surgical or radiological procedures);
- (15) Repair of retinal tear, detachment (requiring surgical or radiological procedures);
- (16) Destruction of lesion of retina and choroid (requiring surgical or radiological procedures);
- (17) Diagnostic procedures on eye (requiring surgical or radiological procedures);
- (18) Other therapeutic procedures on eyelids, conjunctiva, cornea (requiring surgical or radiological procedures);
- (19) Other intraocular therapeutic procedures (requiring surgical or radiological procedures);
- (20) Other extraocular muscle and orbit therapeutic procedures (requiring surgical or radiological procedures);
- (21) Tympanoplasty;
- (22) Myringotomy;
- (23) Mastoidectomy;
- (24) Diagnostic procedures on ear (requiring surgical or radiological procedures);

- (25) Other therapeutic ear procedures (requiring surgical or radiological procedures);
- (26) Control of epistaxis (requiring surgical or radiological procedures);
- (27) Plastic procedures on nose (requiring surgical or radiological procedures);
- (28) Oral and Dental Services (requiring surgical or radiological procedures);
- (29) Tonsillectomy or adenoidectomy;
- (30) Diagnostic procedures on nose, mouth and pharynx (requiring surgical or radiological procedures);
- (31) Other non-operating room therapeutic procedures on nose, mouth and pharynx (requiring surgical procedures);
- (32) Other operating room therapeutic procedures on nose, mouth and pharynx (requiring surgical or radiological procedures);
- (33) Tracheostomy, temporary and permanent;
- (34) Tracheoscopy and laryngoscopy with biopsy;
- (35) Lobectomy or pneumonectomy;
- (36) Diagnostic bronchoscopy and biopsy of bronchus (requiring surgical or radiological procedures);
- (37) Other diagnostic procedures on lung and bronchus (requiring surgical or radiological procedures);
- (38) Incision of pleura, thoracentesis, chest drainage;
- (39) Other diagnostic procedures of respiratory tract and mediastinum (requiring surgical or radiological procedures);
- (40) Other non-operating room therapeutic procedures on respiratory system (requiring surgical procedures);
- (41) Other operating room therapeutic procedures on respiratory system (requiring surgical or radiological procedures);
- (42) Heart valve procedures;
- (43) Coronary artery bypass graft (CABG);

- (44) Percutaneous transluminal coronary angioplasty (PTCA);
- (45) Coronary thrombolysis (requiring surgical or radiological procedures);
- (46) Diagnostic Cardiovascular (Cardiac) catheterization, coronary arteriography;
- (47) Insertion, revision, replacement, removal of Cardiovascular (Cardiac) pacemaker or cardioverter/defibrillator (requiring surgical or radiological procedures);
- (48) Other operating room heart procedures (requiring surgical or radiological procedures);
- (49) Extracorporeal circulation auxiliary to open heart procedures (requiring surgical or radiological procedures);
- (50) Endarterectomy, vessel of head and neck;
- (51) Aortic resection, replacement or anastomosis;
- (52) Varicose vein stripping, lower limb;
- (53) Other vascular catheterization, not heart;
- (54) Peripheral vascular bypass;
- (55) Other vascular bypass and shunt, not heart;
- (56) Creation, revision and removal of arteriovenous fistula or vessel-to-vessel cannula for dialysis;
- (57) Hemodialysis;
- (58) Other operating room procedures on vessels of head and neck (requiring surgical or radiological procedures);
- (59) Embolectomy and endarterectomy of lower limbs (requiring surgical or radiological procedures);
- (60) Other operating room procedures on vessels other than head and neck (requiring surgical or radiological procedures);
- (61) Other diagnostic cardiovascular procedures (requiring surgical or radiological procedures);

(62) Other non-operating room therapeutic cardiovascular procedures (requiring surgical or radiological procedures);

(63) Bone marrow transplant;

(64) Bone marrow biopsy;

(65) Procedures on spleen (requiring surgical or radiological procedures);

(66) Other therapeutic procedures, hemic or lymphatic system (requiring surgical or radiological procedures);

(67) Ligation of esophageal varices;

(68) Esophageal dilatation (requiring surgical or radiological procedures)

(69) Upper gastrointestinal endoscopy, biopsy;

(70) Gastrostomy, temporary or permanent;

(71) Colostomy, temporary or permanent;

(72) Ileostomy and other enterostomy;

(73) Gastrectomy, partial or total;

(74) Small bowel resection;

(75) Colonoscopy or biopsy;

(76) Proctoscopy or anorectal biopsy;

(77) Colorectal resection;

(78) Local excision of large intestine lesion (not endoscopic);

(79) Appendectomy;

(80) Hemorrhoid procedures (requiring surgical or radiological procedures);

(81) Endoscopic retrograde cannulation of pancreas (ERCP);

(82) Biopsy of liver;

(83) Cholecystectomy or common duct exploration (requiring surgical or radiological procedures);

(84) Inguinal or femoral hernia repair (requiring surgical or radiological procedures);

(85) Other hernia repair (requiring surgical or radiological procedures);

(86) Laparoscopy;

(87) Abdominal paracentesis;

(88) Exploratory laparotomy;

(89) Excision, lysis peritoneal adhesions (requiring surgical or radiological procedures);

(90) Other bowel diagnostic procedures (requiring surgical or radiological procedures);

(91) Other non-operating room upper GI therapeutic procedures (requiring surgical or radiological procedures);

(92) Other operating room upper GI therapeutic procedures (requiring surgical or radiological procedures);

(93) Other non-operating room lower GI therapeutic procedures (requiring surgical or radiological procedures);

(94) Other operating room lower GI therapeutic procedures (requiring surgical or radiological procedures);

(95) Other gastrointestinal diagnostic procedures (requiring surgical or radiological procedures);

(96) Other non-operating room gastrointestinal therapeutic procedures (requiring surgical or radiological procedures);

(97) Other operating room gastrointestinal therapeutic procedures (requiring surgical or radiological procedures);

(98) Endoscopy or endoscopic biopsy of the urinary tract;

(99) Transurethral excision, drainage, or removal urinary obstruction (requiring surgical or radiological procedures);

(100) Ureteral catheterization;

- (101) Nephrotomy or nephrostomy;
- (102) Nephrectomy, partial or complete;
- (103) Kidney transplant;
- (104) Genitourinary incontinence procedures (requiring surgical or radiological procedures);
- (105) Extracorporeal lithotripsy, urinary (requiring surgical or radiological procedures);
- (106) Indwelling catheter;
- (107) Procedures on the urethra (requiring surgical or radiological procedures);
- (108) Other diagnostic procedures of urinary tract (requiring surgical or radiological procedures);
- (109) Other non-operating room therapeutic procedures of urinary tract (requiring surgical or radiological procedures);
- (110) Other operating room therapeutic procedures of urinary tract (requiring surgical or radiological procedures);
- (111) Transurethral resection of prostate (TURP);
- (112) Open prostatectomy;
- (113) Circumcision;
- (114) Diagnostic procedures, male genital (requiring surgical or radiological procedures);
- (115) Other non-operating room therapeutic procedures, male genital (requiring surgical or radiological procedures);
- (116) Other operating room therapeutic procedures, male genital (requiring surgical or radiological procedures);
- (117) Oophorectomy, unilateral or bilateral;
- (118) Other operations on ovary (requiring surgical or radiological procedures);
- (119) Ligation of fallopian tubes (requiring surgical or radiological procedures);

- (120) Removal of ectopic pregnancy (requiring surgical or radiological procedures);
- (121) Other operations on fallopian tubes (requiring surgical or radiological procedures);
- (122) Hysterectomy, abdominal or vaginal (requiring surgical or radiological procedures);
- (123) Other excision of cervix or uterus;
- (124) Abortion (termination of pregnancy);
- (125) Dilatation and curettage (D&C), aspiration after delivery or abortion (requiring surgical or radiological procedures);
- (126) Diagnostic dilatation and curettage (D&C);
- (127) Repair of cystocele or rectocele, obliteration of vaginal vault (requiring surgical or radiological procedures);
- (128) Other diagnostic procedures, female organs (requiring surgical or radiological procedures);
- (129) Other non-operating room therapeutic procedures, female organs (requiring surgical or radiological procedures);
- (130) Other operating room therapeutic procedures, female organs (requiring surgical or radiological procedures);
- (131) Episiotomy;
- (132) Cesarean section;
- (133) Forceps, vacuum, or breech delivery (requiring surgical or radiological procedures);
- (134) Artificial Rupture of membranes to assist delivery (requiring surgical procedures);
- (135) Other procedures to assist delivery (requiring surgical or radiological procedures);
- (136) Diagnostic amniocentesis;
- (137) Fetal monitoring (requiring surgical or radiological procedures);

- (138) Repair of current obstetric laceration;
- (139) Other therapeutic obstetrical procedures (requiring surgical or radiological procedures);
- (140) Partial excision bone;
- (141) Bunionectomy or repair of toe deformities (requiring surgical or radiological procedures);
- (142) Treatment, facial fracture or dislocation (requiring surgical or radiological procedures);
- (143) Treatment, fracture or dislocation of radius and ulna (requiring surgical or radiological procedures);
- (144) Treatment, fracture or dislocation of hip and femur (requiring surgical or radiological procedures);
- (145) Treatment, fracture or dislocation of lower extremity (other than hip or femur) (requiring surgical or radiological procedures);
- (146) Other fracture and dislocation procedure (requiring surgical or radiological procedures);
- (147) Arthroscopy;
- (148) Division of joint capsule, ligament or cartilage;
- (149) Excision of semilunar cartilage of knee;
- (150) Arthroplasty knee;
- (151) Hip replacement, total or partial;
- (152) Arthroplasty other than hip or knee;
- (153) Arthrocentesis;
- (154) Injections and aspirations of muscles, tendons, bursa, joints and soft tissue (requiring surgical or radiological procedures);
- (155) Amputation of lower extremity;
- (156) Spinal fusion (requiring surgical or radiological procedures);

(157) Other diagnostic procedures on musculoskeletal system (requiring surgical or radiological procedures);

(158) Other therapeutic procedures on muscles and tendons (requiring surgical or radiological procedures);

(159) Other operating room therapeutic procedures on bone (requiring surgical or radiological procedures);

(160) Other operating room therapeutic procedures on joints (requiring surgical or radiological procedures);

(161) Other non-operating room therapeutic procedures on musculoskeletal system (requiring surgical or radiological procedures);

(162) Other operating room therapeutic procedures on musculoskeletal system (requiring surgical or radiological procedures);

(163) Breast biopsy or other diagnostic procedures on breast (requiring surgical or radiological procedures);

(164) Lumpectomy, quadrantectomy of breast;

(165) Mastectomy;

(166) Incision and drainage, skin and subcutaneous tissue (requiring surgical or radiological procedures);

(167) Excision of skin lesion;

(168) Suture of skin or subcutaneous tissue;

(169) Skin graft;

(170) Other diagnostic procedures on skin or subcutaneous tissue;

(171) Other non-operating room therapeutic procedures on skin or breast (requiring surgical or radiological procedures);

(172) Other operating room therapeutic procedures on skin or breast (requiring surgical or radiological procedures);

(173) Other organ transplantation;

(174) Computerized axial tomography (CT) scan head;

- (175) Computerized axial tomography (CT) scan chest;
- (176) Computerized axial tomography (CT) scan abdomen;
- (177) Other Computerized axial tomography (CT) scan;
- (178) Myelogram;
- (179) Mammography;
- (180) Routine chest X-ray;
- (181) Intraoperative cholangiogram;
- (182) Upper gastrointestinal X-ray;
- (183) Lower gastrointestinal X-ray;
- (184) Intravenous pyelogram;
- (185) Cerebral arteriogram;
- (186) Contrast aortogram;
- (187) Contrast arteriogram of femoral or lower extremity arteries;
- (188) Arteriogram or venogram (not heart or head);
- (189) Diagnostic ultrasound of head or neck;
- (190) Diagnostic ultrasound of heart (echocardiogram);
- (191) Diagnostic ultrasound of gastrointestinal tract;
- (192) Diagnostic ultrasound of urinary tract;
- (193) Diagnostic ultrasound of abdomen or retroperitoneum;
- (194) Other diagnostic ultrasound;
- (195) Magnetic resonance imaging;
- (196) Electroencephalogram (EEG) (requiring surgical or radiological procedures);

- (197) Swan-Ganz catheterization for monitoring;
- (198) Radioisotope bone scan;
- (199) Radioisotope pulmonary scan;
- (200) Radioisotope scan or function studies;
- (201) Other radioisotope scan;
- (202) Therapeutic Radiology
- (203) Traction, splints, or other wound care (requiring surgical or radiological procedures);
- (204) Ophthalmologic or otologic diagnosis and treatment (requiring surgical or radiological procedures);
- (205) Nasogastric tube (requiring radiological procedures);
- (206) Blood transfusion;
- (207) Parenteral nutrition (via intravenous methods);
- (208) Cancer chemotherapy (requiring surgical or radiological procedures);
- (209) Conversion of Cardiovascular (Cardiac) rhythm;
- (210) Other diagnostic radiology and related (requiring surgical or radiological procedures);
- (211) Other therapeutic procedures (requiring surgical or radiological procedures);
- (212) Infertility Services (requiring surgical or radiological procedures);
- (213) Medications (Infusions and other forms requiring surgical or radiological procedures); and
- (214) Gastric bypass and volume reduction (requiring surgical or radiological procedures).

(h) [(g)] This section is effective 90 calendar days after being published in the Texas Register. The department will not implement or enforce this section until September 1, 2011 [July 1, 2009], at the earliest.

§421.68. Event Data Release.

(a) DSHS records are public records under Government Code, Chapter 552, except as specifically exempted by Health and Safety Code, §§108.010, 108.011 and 108.013 or other state or federal law. Copies of such records may be obtained upon request and upon payment of user fees established by DSHS. The public use data file shall be available for public inspection during normal business hours. Event claims in any **[the original]** format as submitted to DSHS are not available to the public [, **are not stored at DSHS**] and are exempt from disclosure pursuant to Health and Safety Code, §§108.010, 108.011 and 108.013, and shall not be released. Likewise, patient and physician identifying data collected by the DSHS through editing of facility data shall not be released.

(b) - (i) (No change.)

[(j) This section is effective 90 calendar days after being published in the Texas Register. The department will not implement or enforce this section until July 1, 2009 at the earliest]