DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED RULES

1) Heading of the Part: Health Care Data Collection and Submission Code

2) Code Citation: 77 Ill. Adm. Code 1010

3) Section Numbers: Proposed Action:

1010.10	New
1010.20	New
1010.30	New
1010.40	New
1010.50	New
1010.60	New
1010.70	New
1010.Appendix A	New
1010.Appendix B	New
1010.Appendix C	New
1010.Appendix D	New
1010.Appendix E	New
1010.Appendix F	New
1010.Appendix G	New
1010.Appendix H	New
1010.Appendix I	New
1010.Appendix J	New

4) Statutory Authority: Illinois Health Finance Reform Act [20 ILCS 2215] and Sections 2310-33 and 2310-57 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois [20 ILCS 2310-33 and 2310-57].

5) A Complete Description of the Subjects and Issues Involved: These rules implement the Health Finance Reform Act as amended by Public Act 94-27, effective June 14, 2005, and the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois as amended by Public Act 94-501, effective August 8, 2005. The Health Care Data Collection and Submission Code requires individual hospitals and ambulatory surgical treatment centers to electronically submit claims and encounter data related to inpatient discharges and outpatient cases involving surgical and invasive procedures. Data collected from hospitals and ambulatory surgical treatment centers will be used in part to compile the “Consumer Guide to Health Care”, a report of at least 60 conditions and procedures demonstrating the widest variation in charges and quality of care. National standard measures will be applied to Illinois data in the development of this public report to be made available on the Department’s web site. The “Consumer Guide

to Health Care" shall include inpatient and outpatient data with current comparison information related to, but not limited to, volume of cases, average charges, risk-adjusted mortality rates, complications, nosocomial infections and surgical infections. The "Consumer Guide to Health Care" shall include additional information appropriate for interpretation of report content, explanation of causes of variation from provider to provider and a description of standards that facilities meet under voluntary accreditation and state and federal law. The Department will evaluate additional methods of comparing the performance of hospitals and ambulatory surgical treatment centers using accepted national standard measures and methodologies. Data collected under PA 94-027 shall be made available, with certain limitations, to government agencies, academic research organizations and private sector organizations for clinical performance measures and analyses. The Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois authorizes the Department to establish a fee schedule for the sale of these data to requesting agencies and organizations.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None.

7) Will this rulemaking replace any emergency rulemaking currently in effect? No.

8) Does this rulemaking contain an automatic repeal date? No.

9) Does this rulemaking contain incorporations by reference? Yes.

10) Are there any other proposed rulemakings pending on this Part? No.

11) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State Mandate.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking:

Interested persons may present their comments concerning this rulemaking within 45 days after this issue of the *Illinois Register* to:

Susan Meister
Division of Legal Services
Illinois Department of Public Health
535 W. Jefferson St., 5th floor
Springfield, Illinois 62761

217/782-2043
e-mail: rules@idph.state.il.us

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: hospitals and ambulatory surgical treatment centers

B) Reporting, bookkeeping or other procedures required for compliance: reporting of clinical and related information regarding patients served

C) Types of professional skills necessary for compliance: clerical, computer programming, computer operation, filing, report reading and data interpretation

14) Regulatory Agenda on which this rulemaking was summarized:

July 2006

The full text of the Proposed Rule begins on the next page:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED RULES

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER x: HEALTH STATISTICS

PART 1010
HEALTH CARE DATA COLLECTION AND SUBMISSION CODE

Section

AUTHORITY: Implementing and authorized by the Illinois Health Finance Reform Act [20 ILCS 2215] and Sections 2310-33 and 2310-57 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois [20 ILCS 2310/2310-33 and 2310-57].

SOURCE: Adopted at 31 Ill. Reg._____, effective _____.

Section 1010.10 Purpose

This Part is promulgated under the authority of Section 4-2 of the Illinois Health Finance Reform Act [20 ILCS 2215/4-2] and Section 2310-57 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois [20 ILCS 2310/2310–57]. Its purpose is to provide to consumers, health care providers, insurers, purchasers, governmental agencies, and

others information to make valid comparisons among health care facilities of prices and performance of services provided and to support ongoing analysis of the health care delivery system in Illinois.

Section 1010.20 Definitions

Unless otherwise indicated, in this Part:

"Affirmation statement" means a document that, when signed by a hospital or ambulatory surgical treatment center administrator or an authorized representative of a hospital or ambulatory surgical treatment center submitting data to the Department, affirms, to the best of the signer's knowledge, all of the following:

That any necessary corrections to data submitted to the Department have been made; and

That the data submitted are complete and accurate.

"AHRQ" means the Agency for Healthcare Research and Quality, a part of the U.S. Department of Health and Human Services.

"Ambulatory surgical treatment center" has the meaning ascribed to that term under Section 3 of the Ambulatory Surgical Treatment Center Act [210 ILCS 5].

"APC" means ambulatory patient classification, as defined by the Centers for Medicare and Medicaid Services (Medicare), for the prospective payment system (PPS) under Medicare for hospital outpatient services. All services paid under the PPS are classified into groups called APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC based on the resources involved in treatment.

"CCS" means Clinical Classification Software, a diagnosis and procedure categorization scheme developed by the Healthcare Cost and Utilization Project.

"CCYYMMD" means a calendar date in the format of century, year, month and day of the week, where 1 = Sunday, 2 = Monday, etc.

"CCYYMMDD" means a calendar date in the format of century, year, month and day, without separators.

"Claims and encounter" means either of the following:

A request to obtain payment, and necessary accompanying information, from a health care provider to a health plan, for health care; or

An inpatient stay or outpatient visit in which a claim is not generated.

"Cleaned claims data" means data that have passed validity tests that edit for individual element content and comparison with related elements for appropriate context within the time periods and value ranges appropriate for the data file.

"Compliance Percentage" means the value obtained when the number of cleaned and unduplicated claims and encounters per calendar month is divided by the reported discharge count for the same calendar month, with the dividend of this calculation multiplied by 100.

"Consumer Guide to Health Care" means a comparative health care information report showing conditions and procedures that demonstrate the widest variation in charges and quality of care in inpatient and outpatient services provided in hospitals and ambulatory surgical treatment centers.

"CPT" means Current Procedural Terminology, a listing of descriptive terms and identifying codes providing a consistent and standardized language for reporting medical services and procedures performed by physicians. These codes are maintained and distributed by the American Medical Association (515 North State Street, Chicago IL 60610).

"Custom dataset" means requests for specific data elements for particular research or reporting tasks. This may include specific aggregations or combinations of data values into categories or groups.

"Data submission profile" means a set of validation and verification reports containing accumulated statistical summaries of all data submitted to the Department by the facility for each month of the current collection period. These reports contain information identifying claims and encounters that fail Departmental edits as well as data quality statistics showing data accepted up to and including the latest submission.

"Data submission manual" means the Department's Technical Reference for Data Submission document specifying the details of the record layout, the outpatient surgical procedure code range, specifications of identification of emergency department and observation cases and contact information for questions related to data submission.

"Data use agreement" means a written contract between parties that defines the care and handling of sensitive or restricted use data, including but not limited to, the terms of the agreement, ownership of the data, security measures and access to the data, uses of the data, data confidentiality procedures, duration of the agreement, disposition of the data at the completion of the contract, and any penalties for violation of the terms of the agreement.

"De-identified" means data that do not contain directly identifiable individual patient health information as defined in the Health Information Portability and Accountability Act privacy regulations (Security and Privacy: 45 CFR 164), or that, through analysis by an experienced expert statistician or by the use of probability software, can be shown to have a low probability of individual identification.

"Department" means the Illinois Department of Public Health.

"DRG" means Diagnosis Related Group, a patient classification scheme that provides a means of categorizing hospital inpatients according to the resources required in treatment, developed for the Centers for Medicare and Medicaid Services for use in the Medicare Prospective Payment System.

"Electronically submit" means that required data submission will be carried out by the transfer of appropriate file(s) to the Department's secure web server. Physical media of any form or type will not be used in the transfer of these data.

"Emergency Department (ED)" means the location within hospitals where persons receive initial treatment by health care professionals for conditions of an immediate nature caused by injury or illness. The person treated may or may not be admitted to the hospital as an inpatient.

"Emerging technology" means new approaches to the treatment of medical conditions through the use of existing machines and equipment in new and

different ways or the development of new machines and equipment for a specific form of medical treatment.

"Ethnicity" means the classification of a person's ethnic background. Classification categories collected will follow the Federal Office of Management and Budget (OMB) Statistical Policy Directive Number 15, "Race and Ethnic Standards for Federal Statistics and Reporting."

"Facility" means a hospital, as defined in the Hospital Licensing Act [210 ILCS 85] and the University of Illinois Hospital Act [110 ILCS 330], or an ambulatory surgical treatment center, as defined in the Ambulatory Surgical Treatment Center Act [210 ILCS 5].

"Final closing date" means the final day, 65 days after the end of each calendar quarter, on which electronically submitted corrections and missing data are accepted for each quarterly data submission period.

"FIPS" means Federal Information Processing Standards, a standardized set of numeric or alphabetic codes issued by the National Institute of Standards and Technology (NIST) to ensure uniform identification of geographic entities through all federal government agencies.

"HCPCS" means the Healthcare Common Procedure Coding System, a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT). The HCPCS was established to provide a standardized coding system for describing the specific items and services provided in the delivery of health care. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) made the HCPCS mandatory for Medicare and Medicaid billings. HCPCS includes three levels of codes:

Level I consists of the American Medical Association's Current Procedural Terminology (CPT) and is numeric.

Level II codes are alphanumeric and primarily include non-physician services such as ambulance services and prosthetic devices.

Level III consists of temporary codes for emerging technologies, services and procedures.

"HCUP" means the Healthcare Cost and Utilization Project, a group of health care databases and software tools and products created by a government and industry partnership and sponsored by the AHRQ.

"Health plan" means an individual or group plan that provides, or pays the cost of, medical care. Further explanation can be found in the Health Insurance Portability and Accountability Act privacy regulations (Security and Privacy: 45 CFR 164).

"HHMM" means clock time in hour and minute format, with no separators.

"HIPAA" means Health Insurance Portability and Accountability Act of 1996 [110 U.S.C 1936].

"Health Insurance Portability and Accountability Act privacy regulations" means regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"Hospital" means any institution, place, building, or agency, public or private, whether organized for profit or not for profit, that is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act, and the University of Illinois Hospital as defined in the University of Illinois Hospital Act.

"Initial closing date" means the date, 60 days after the end of each calendar quarter, established for all hospitals and ambulatory surgical treatment centers to electronically submit inpatient and outpatient claims and encounter data to the Department.

"Invasive" means a medical procedure that penetrates or breaks the skin or a body cavity by means of a perforation, incision, catheterization or other methods into a patient's body.

"Limited datasets" means data containing protected health information (PHI) that excludes certain direct identifiers of the individual or of relatives, employers or household members of the individual, as defined in the Health Insurance Portability and Accountability Act privacy regulations.

"MDC" means Major Diagnostic Category, a collection of DRGs for categorizing specifically defined interventions and illnesses related to an organ or a body system, not to the cause of an illness or injury.

"Minimally invasive" means a medical procedure carried out by entering the body through the skin or through a body cavity or anatomical opening, but with the smallest disturbance possible to these structures. Special medical equipment may be used, such as fiber optic cables, miniature video cameras, and special surgical instruments handled via tubes inserted into the body through small openings in its surface.

"Non-invasive surgery" means a medical procedure using highly focused beam(s) of radiation when the nature or location of the condition is not amenable to mechanical intervention.

"NPI" means National Provider Identifier, a unique identification number assigned to all health care providers to be used by all health plans. The NPI will be issued and maintained by the National Provider System.

"Observation care (OC)" means services furnished to a person by a hospital on the hospital's premises, including use of a bed and at least periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient. In general, the duration of observation care services does not exceed 24 hours, although in some circumstances, patients may require a second day.

"Outpatient" means any health care service provided in a hospital to a patient who is not admitted as an inpatient to the hospital, or any health care service provided to a patient in a licensed ambulatory surgical treatment center.

"Outpatient surgery" means specific procedures performed on an outpatient basis in a hospital or licensed ambulatory surgical treatment center. Specific ranges of required procedure codes can be found in the Department's data submission manual.

"PHI" means personal health information as defined in the Health Information Portability and Accountability Act privacy regulations.

"Public use data" means any form of data from the Department's comprehensive discharge database or facility-level database that contains de-identified data.

"Race" means the classification of a person's racial background. Classification categories collected will follow the Federal Office of Management and Budget (OMB) Statistical Policy Directive Number 15, "Race and Ethnic Standards for Federal Statistics and Reporting."

"Raw data" means any file, individual record, or any subset thereof that contains information about an individual health care service provided to a single patient and is released by the Department in data products or custom data files.

"Reciprocal data availability" means that if a data requester controls the discharge data of another state, release of Illinois discharge data to that state entity would be contingent on the availability of discharge data from that state of comparable quantity, quality, and content at a similar price point.

"Research" means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities that meet this definition constitute research, whether or not they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities.

"Small number" means any number that is small enough to be useful in an attempt to determine the identity of a specific individual patient when used in conjunction with other elements in the data file or when the data file is linked with information from other sources. The Department considers a small number to be any cell size fewer than 10.

"Surgery" means treatment of diseases or injuries by manual and/or instrumental methods. Such methods may include invasive, minimally invasive or non-invasive procedures, depending on the condition treated and the nature of the instruments and technology used.

"Uniform" means related unique data values that are combined into a smaller number of common categories.

"UPIN" means Unique Physician Identification Number, a unique identification number assigned to all Medicare providers. The UPIN Registry is maintained by the National Heritage Insurance Company under contract from the Centers for Medicare and Medicaid Services.

Section 1010.30 Incorporated and Referenced Materials

The following materials are incorporated or referenced in this Part:

a) Federal regulations

1) Prospective Payment Systems for Inpatient Hospital Services (42 CFR 412), October 1, 2005

2) Medical Facility Construction and Modernization (42 CFR 124), October 1, 2005

3) Security and Privacy (45 CFR 164), October 1, 2005

b) Federal guidelines

"Race and Ethnic Standards for Federal Statistics and Reporting" Statistical Policy Directive Number 15, Federal Office of Management and Budget (OMB), October 30, 1997

c) Federal statutes

1) Gramm-Leach-Bliley Act [12 U.S.C. 1811]

2) Social Security Act [42 U.S.C. 1320]

3) Health Insurance Portability and Accountability Act of 1996 [110 U.S.C. 1936]

d) State statutes

1) Illinois Health Finance Reform Act [20 ILCS 2215]

2) Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois [20 ILCS 2310]

3) University of Illinois Hospital Act [110 ILCS 330]

4) Ambulatory Surgical Treatment Center Act [210 ILCS 5]

5) Hospital Licensing Act [210 ILCS 85]

e) Federal regulations and guidelines incorporated by reference in this Part are incorporated on the date specified and do not include any later amendments or editions.

Section 1010.40 Data Submission Requirements

a) Inpatient and Outpatient Claims and Encounter Data

1) Hospitals and ambulatory surgical treatment centers shall electronically submit patient claims and encounter data, as outlined in this subsection (a), to the Department no later than the initial closing date, 60 calendar days after the last day of each calendar quarter. Calendar quarters shall begin on January 1, April 1, July 1, and October 1 and shall end on March 31, June 30, September 30, and December 31. Beginning no later than 45 days after the last day of each calendar quarter, hospitals and ambulatory surgical treatment centers shall begin an internal review of all quarterly data accepted by the Department.

A) Hospitals shall submit to the Department:

i) All of the patient claims and encounter data pertaining to discharge data for each inpatient as specified in Appendix A, beginning with a transition submission period starting on July 1, 2007. This transition period will end on December 31, 2007, with mandatory submission as specified in Appendix A beginning on January 1, 2008; and

ii) All of the patient claims and encounter data pertaining to case data for each emergency department (ED) visit (wherever care is administered) and each outpatient

observation case (OC) as specified in Appendix C, beginning with a transition submission period starting on April 1, 2008. This transition period will end on December 31, 2008, with mandatory submission of ED and OC data as specified in Appendix C beginning on January 1, 2009.

B) Hospitals and ambulatory surgical treatment centers shall report to the Department:

i) Information relating to any patient treated with an ambulatory surgical procedure within any of the general types of surgeries as specified in Appendix B; and

ii) All of the patient claims and encounter data for each surgical procedure outlined in subsection (a)(1)(B)(i) of this Section as specified in Appendix C, beginning with a transition submission period starting on July 1, 2007. This transition period will end on December 31, 2007, with mandatory submission as specified in Appendix C beginning on January 1, 2008.

C) Hospitals and ambulatory surgical treatment centers shall report data to the Department using the current submission format as specified in the Department's data submission manual until June 30, 2007. Beginning with the start of the transition period on July 1, 2007, data will be accepted either in the current format or in the new format outlined in Appendices A and C and detailed in the Department's data submission manual until the end of the transition period on December 31, 2007. Beginning with submissions received on January 1, 2008, only data consisting of the elements listed in Appendices A and C as detailed in the Department's data submission manual will be accepted.

2) Each hospital and ambulatory surgical treatment center shall electronically submit to the Department all patient claims and encounter data pursuant to this subsection (a) of this Section in accordance with the uniform electronic transaction standards and code set standards adopted by the Secretary of Health and Human Services under the Social Security Act [42 U.S.C. 1320d-2] and the physical specifications, format and record layout

as specified in the Department's data submission manual. Ambulatory surgical treatment centers that are unable to electronically submit data shall submit required data in the specified format on diskette until June 30, 2008. Beginning July 1, 2008, ambulatory surgical treatment centers shall electronically submit all data to the Department.

3) To be considered compliant with this Section, a hospital's or ambulatory surgical treatment center's data submission shall:

A) Be submitted to the Department electronically, as specified in the data submission manual;

B) Consist of an individual facility data file; and

C) Meet the Department's minimum level of data submission compliance on or before the data submission due date:

i) Hospitals shall maintain a compliance percentage of no less than 98% for each calendar month beginning with the calendar month of July 2007.

ii) Ambulatory surgical treatment centers shall maintain a compliance percentage of no less than 90% during the period beginning with calendar month of July 2007. Beginning with the calendar month of April 2008, ambulatory surgical treatment centers shall maintain a monthly compliance percentage of no less than 95%. Thereafter, beginning with the calendar month of April 2009, ambulatory surgical treatment centers shall maintain a monthly compliance percentage of no less than 98%.

4) Failure to comply with this Section may subject the facility to penalties as provided in the Ambulatory Surgical Treatment Center Act [210 ILCS 5] and the Hospital Licensing Act [210 ILCS 85].

b) Inpatient and Outpatient Report of Monthly Discharge and Outpatient Surgery Counts

1) Each hospital shall, within 30 calendar days following the last day of each calendar month, submit:

   A) The actual total number of hospital inpatient discharges for that calendar month. In the case of multiple births, each child is counted as a discharge; and

   B) The actual number of hospital outpatient cases with a surgical procedure as defined in this Part for that calendar month.

2) Effective beginning with calendar month April 2008, each hospital shall, within 30 calendar days following the last day of each calendar month, submit for each category the actual number of hospital outpatient cases with an emergency department visit, observation stay, or surgical procedure as defined in this Part for that calendar month. Each patient shall be counted only once. Outpatient surgical cases, regardless of other services, shall be counted as surgical cases. Non-surgical cases may be counted as combined ED and OC or separately as ED and OC. Patients receiving both services should be counted only once in both counting methods: as combined ED and OC in the combined method or counted as OC (the last service received) in the separate method.

3) Each licensed ambulatory surgical treatment center shall, within 30 calendar days following the last day of each calendar month, submit the actual total number of licensed ambulatory surgical treatment center outpatient cases with a surgical procedure for that calendar month as defined in this Part.

4) All filings required in subsections (a) and (b) of this Section shall be reported using the Department's electronic submission systems.

5) Effective 60 days after the end of each calendar quarter, monthly reported discharge count acceptance for that calendar quarter will end. If any facility finds it necessary to change monthly reported count(s) after the initial closing date and before the final closing date, the revised monthly count shall be submitted by the facility administrator with a written justification.

Section 1010.50 Common Data Verification, Review, and Comment Procedures

a) Each facility shall review its patient discharge data for accuracy and completeness before submitting the data specified in this Part to the Department.

b) The Department will edit each data submission for proper file formatting; content and context edits will be applied to each data element as appropriate; the file will be checked for duplicate records; and the database transaction(s) will result in a data submission profile that will be available in electronic format on the Department's data submission web site.

c) The submitting facility shall obtain and review the data submission profile as specified in subsection (b) of this Section from each data submission to verify that data received and accepted by the Department are in fact a complete and accurate representation of the services provided by the facility during the stated time frames. If a facility or the Department determines that any data are in fact incomplete or inaccurate, it is the facility's responsibility to submit corrected data prior to the final closing date of the affected data collection period.

d) If the Department determines that data submitted by a facility are questionable, inaccurate or incomplete, the Department will notify the facility of the need to audit data submission practices. Upon notification by the Department, all hospitals and ambulatory surgical treatment centers shall provide access to all required information from the medical records and patient claims and encounter data underlying and documenting the inpatient and outpatient data submitted, as well as other related documentation deemed necessary to conduct successful inpatient and outpatient data audits of hospital and ambulatory surgical treatment center data. The facility shall closely monitor future data submissions to ensure that submissions accurately reflect health care services provided. It is the responsibility of each facility to review the results of each data submission for erroneous, inaccurate, incomplete or unreasonable information in data accepted by the Department and to resubmit accurate data prior to the end of the submission period.

e) Final edited data shall be received prior to the final closing date, 20 calendar days after the start date for internal data review as specified in Section 1010.40(a)(1) of this Part. Five calendar days are specified between the initial and final closing dates to correct errors in claims and encounter data that were rejected on the last day of submission. To meet these requirements, the facility shall do all of the following:

1) Correct and re-submit all data rejected throughout the quarterly submission period because of errors revealed by the Department edit checks performed under subsection (b) of this Section, and submit any missing claims and encounter data;

2) Review the resultant data profile for accuracy and completeness; and

3) Supply the Department with an affirmation statement signed by the chief executive officer or designee, indicating that the facility's data are accurate and complete.

f) Failure to comply with subsections (d) and (e) of this Section shall result in the facility's being noncompliant with this Section, and the facility may be subject to penalties as provided in Ambulatory Surgical Treatment Center Act and the Hospital Licensing Act.

g) After the facility has made any revisions under subsection (e) of this Section in the data for a particular time period, a data submission profile will be available for the submitting facility's review.

h) If the Department discovers data errors after releasing the data, or if a facility representative notifies the Department of data errors after the Department releases the data, the Department will note the data errors as caveats to the completed datasets. No revisions or additions to discharge data, case data, or monthly counts will be accepted after the final closing date of each quarterly data collection period. If the Department makes an error in the preparation, presentation or reporting of collected data, the error will be corrected.

Section 1010.60 Data Dissemination

a) The Department will provide facilities the opportunity to review the Consumer Guide to Health Care (Guide) prior to public release. The entire report will be made available to each facility on the Department's secure web server for review before publication. This review period will end 15 working days after the availability date of the review material. During the review period, each facility may submit written comments concerning its report content to the Department. Comments shall be submitted on facility letterhead and shall be signed by the

administrator or designee. All comments received by the Department will be kept on file. No comments will be accepted after the end of the review period, and no changes to the content of the Guide will be accepted. If any facility or the Department finds erroneous or incomplete data in the Guide, these data will be identified and footnoted prior to publication. If the Department makes an error in the preparation or presentation of the Guide, the error will be corrected.

b) Limited Data Products and Reports

1) The Department will charge fees to the requesting entity for providing access to data files or producing studies, data products or analyses of such data. A schedule of fees for standard and custom datasets and products according to category of purchaser is presented in Section 1010.70 of this Part. In determining fees, the Department will consider all of the following:

A) Type of data;

B) Record count and computer time required;

C) Access fees for computer time;

D) Staff time expended to process the request; and

E) Handling and shipping charges.

2) All requests for data files, data products, aggregations or reports containing limited data elements shall be made in writing to the Department. All data obtained from the Department shall be used solely for the purpose identified by the requesting entity and for use by the requesting entity. Use of the data for any other purpose shall require a separate and specific written request and approval.

3) When facility-specific data, reporting or comparative analysis is prepared by the Department, affected facilities will be given the opportunity to review and comment on the data, studies or reports and their content prior to release to the public. Facilities will be provided access to the entire report on the Department's secure web server for review prior to publication. The review period will end 15 working days after the

availability date of the review material. While no changes to previously submitted data will be accepted, the Department will accept written comments and explanations from facilities during the review period. The Department will keep these comments and explanations on file and, as appropriate and reasonable, will incorporate them into the text description of the published report, study or analyses. If a Departmental error is found in such publication, the error will be corrected.

c) De-identified Data Files and Reports

1) Public use data files, reports and studies based on information submitted by hospitals and ambulatory surgical treatment centers shall contain de-identified data, and shall comply with state and federal law, including, but not limited to, the Gramm-Leach-Bliley Act [12 U.S.C. 1811 et seq.] and the Health Insurance Portability and Accountability Act privacy regulations (Security and Privacy: 45 CFR 164).

2) All requests for public use files or special compilations, reports, studies or analyses derived from public use files shall be made in writing to the Department. The release of data related to an approved public use data request shall not require a data use agreement.

Section 1010.70 Data Customer Categories and Data Product Fee Schedule

This Section establishes customer categories, data product descriptions, and data product fees.

a) Customer categories are established as follows:

1) Category I: Resellers

A) Any corporation, association, coalition, person, entity or individual that redistributes in any form any of the data or products (or any subset thereof) obtained from the Department for any revenue is engaged in reselling of such data or products and shall pay for the data or products at the reseller rate.

B) All redistribution shall be restricted to de-identified data as defined by the Health Insurance Portability and Accountability Act of 1996 privacy regulations (Security and Privacy: 45 CFR 164).

2) Category II: Commercial, Private, For-Profit Organizations and Non-Illinois State Government Entities

A) Any corporation, association, coalition, person, entity or individual that functions in whole or in part for the benefit of the owners, members, or sponsors of the corporation or organization seeking to obtain data or products (or any subset thereof) from the Department is presumed to be acquiring the data or products for a commercial use.

B) Any non-profit organization that purchases data materials on behalf of, either in whole or in part, or receives payment from for-profit organizations for work done is presumed to be acquiring the data or products for a commercial use.

C) Non-Illinois state and local government data release will be contingent on reciprocal data availability.

3) Category III: Federal government, educational institutions, all non-profit organizations and college students enrolled in non-Illinois educational institutions, including:

A) The federal government and other non-state or local political subdivisions outside of the State of Illinois.

B) All educational institutions (Illinois and non-Illinois), all non-profit organizations, and all college students enrolled in non-Illinois educational institutions.

4) Category IV: Illinois General Assembly, Executive Office of the Governor, State of Illinois Constitutional Officers, Agencies of Illinois State Government, Illinois county and local government, and college students enrolled in Illinois educational institutions.

b) The following data products are available at rates established by the Department:

1) Standard datasets are defined sets of data elements

A) Research Oriented Dataset (RODS) containing data elements listed in Appendix D of this Part.

B) Universal Dataset (UDS) containing data elements listed in Appendix E of this Part.

C) State Inpatient Database (SID) containing elements derived for the purposes of the HCUP, Appendix F of this Part.

D) State Ambulatory Surgery Database (SASD) containing elements derived for the purposes of the HCUP, Appendix G of this Part.

E) Revenue Code Dataset (RCD), a supplement to datasets A through D containing data elements listed in Appendix H of this Part.

2) The Department will evaluate requests for custom datasets and make the determination of complex or simple based on details of the request.

A) Complex dataset: a subset of RODS, UDS, SID or SASD (with or without RCD) that contains the majority of significant data elements, or an intricate aggregation or report that includes many significant data elements and compound relationships.

B) Simple dataset: a subset of RODS, UDS, SID or SASD (without RCD) that contains a small number of significant data elements, or a straightforward aggregation or report that includes few significant data elements and no or a small number of relationships.

c) Standard data product fees by category are set forth in Appendix I of this Part. In addition to standard data product fees, the Department will assess data request processing and data product preparation fees as follows:

A) The Department will assess a non-refundable data request application fee of $100. The application fee shall be applied to the final cost of approved and completed data products.

B) The Department will assess fees for the costs of preparing requested data products, including, but not limited to, programming, research,

administrative, media and shipping as described in Appendix J of this Part. The minimum charge will be one unit per resource factor, with additional units as necessary for more complicated requests.

Section 1010.Appendix A: Uniform Inpatient Discharge Data

Header Data

1. Hospital ID (federal tax identification number/Department assigned/NPI)
2. Facility name and address (in the header record for verification)
3. Facility city
4. Facility zip code
5. Contact person
6. Telephone number
7. Period covered: first day
8. Period covered: last day

Detail Data

1. Hospital identifier (federal tax identification number/Department assigned/NPI)
2. Patient account number
3. Discharge time (hour)
4. Patient zip code and Plus 4
5. Patient birth date (MMDDCCYY)
6. Patient sex
7. Admission date (MMDDYY) and time (hour)

8. Type of admission

9. Source of admission

10. Patient discharge status

11. Type of bill

12. Total patient charges and components of charges (by revenue code, units of service and charges)

13. Primary payer ID and health plan name

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

15. Principal and secondary diagnosis codes, when present (up to 25)

16. Principal and secondary procedure codes and dates (MMDDYY), when present (up to 25)

17. Attending clinician ID number/NPI

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

19. Patient race (according to OMB guidelines)

20. Patient ethnicity (according to OMB guidelines)

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

22. Diagnosis present at admission for each diagnosis

23. External cause of injury codes (up to 3 required when present)

24. Newborn birth weight value code and birth weight in grams

25. Admitting diagnosis code

26. Do not resuscitate indicator (entered in first 24 hours of stay)

27. Prior stay occurrence code and prior stay from and through dates (required when present)

28. Operating clinician ID number/NPI) (required when surgical procedure(s) present as a component of treatment)

29. Accident state abbreviation (required when present)

30. Condition employment related (required when present)

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

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

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

34. Insurance group numbers (up to 3 required when present)

35. Page number and total number of pages

36. Diagnoses code version qualifier (9=ICD-9, ICD-10 not yet implemented)

Trailer Data

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

2. Number of physical records in the file excluding header and trailer

Section 1010.Appendix B: Ambulatory Surgical Categories Reported by CPT Procedure Codes

1. Surgeries on the integumentary system

2. Surgeries on the musculoskeletal system

3. Surgeries on the respiratory system

4. Surgeries on the cardiovascular system

5. Surgeries on the hemic and lymphatic systems

6. Surgeries on the mediastinum and diaphragm

7. Surgeries on the digestive system

8. Surgeries on the urinary system

9. Surgeries on the male genital system

10. Intersex surgery

11. Surgeries on the female genital system

12. Surgeries on the female reproductive system

13. Surgeries on the endocrine system

14. Surgeries on the nervous system

15. Surgeries on the eye and ocular adnexa

16. Surgeries on the auditory system

Section 1010.Appendix C: Ambulatory Surgical Data Elements

Header Data

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

2. Facility name and address (in the header record for verification)

3. Facility city

4. Facility zip code

5. Contact person

6. Telephone number

7. Period covered: first day

8. Period covered: last day

9. Surgical site identifier (Department assigned)

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 (hour) of visit

8. Time (hour) 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)

17. Principal and secondary procedure codes and dates (MMDDYY), when present (up to 25). 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 (up to 3 required when present)

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 3 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 3 required when present)

32. Diagnoses code version qualifier (9=ICD-9, ICD-10 not yet implemented)

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

Trailer Data

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

2. Surgical site identifier (Department assigned)

3. Number of physical records in file excluding header and trailer

Section 1010.Appendix D: Research Oriented Dataset (RODS) Data Elements

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

2. Patient sex

3. Admission/visit type

4. Admission/visit source

5. Length of stay (in whole days; inpatient only)

6. Patient discharge status

7. Principal diagnosis code and up to 24 secondary codes

8. Principal procedure code and up to 24 secondary codes

9. DRG code inpatient/APC outpatient

10. MDC code inpatient/Body system outpatient

11. Total Charges

12. Room/board charges (inpatient only)
13. Ancillary charges
14. Anesthesiology charges
15. Pharmacy charges
16. Radiology charges
17. Clinical lab charges
18. Labor/delivery charges (inpatient only)
19. Operating room charges
20. Oncology charges
21. Other charges
22. Combined bill indicator (inpatient only)
23. Patient county
24. Patient planning area
25. Patient Health Service Area
26. Hospital Health Service Area
27. Patient date of birth (CCYYMMDD)
28. Admission date (CCYYMMDD) and time (HH)
29. Discharge Date (CCYYMMDD) and time (HH)
30. Primary, secondary and tertiary payer IDs and health plan names (when available)
31. Patient zip code in every record

32. Primary surgical procedure date (if present)

33. Patient race

34. Patient ethnicity

35. Newborn birth weight in grams

36. Do Not Resuscitate (DNR) (inpatient only)

37. Condition employment related

38. Accident employment related

39. Crime victim

40. Admitting diagnosis code/Reason for visit code

41. Diagnosis present at admission for each diagnosis code (inpatient only)

42. Ecodes (when present: up to three)

43. Row ID (when necessary: provides linkage to Revenue Code Dataset)

Section 1010.Appendix E: Universal Dataset (UDS) Data Elements

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

2. Patient sex

3. Admission/visit type

4. Admission/visit source

5. Length of stay (in whole days) (inpatient only)

6. Patient discharge status

7. Principal diagnosis code and up to 24 secondary codes

8. Principal procedure code and up to 24 secondary codes
9. DRG code inpatient/APC outpatient
10. MDC code inpatient/Body system outpatient
11. Total Charges
12. Room/board charges (inpatient only)
13. Ancillary charges
14. Anesthesiology charges
15. Pharmacy charges
16. Radiology charges
17. Clinical lab charges
18. Labor/delivery charges (inpatient only)
19. Operating room charges
20. Oncology charges
21. Other charges
22. Combined bill indicator (inpatient only)
23. Primary health plan type
24. Secondary health plan type
25. Tertiary health plan type
26. Patient county
27. Patient planning area

28. Patient Health Service Area

29. Hospital Health Service Area

30. Patient age (in whole years)

31. Admission date (CCYYMMD)

32. Patient zip code (zip masked when hospital/zip cell size less than 10)

33. Newborn birth weight in grams

34. Do Not Resuscitate (DNR) (inpatient only)

35. Hospitalization employment related

36. Admitting diagnosis code

37. Diagnosis present at admission for each diagnosis code (inpatient only)

38. Ecodes (up to three)

39. Number of days between admission and primary procedure (inpatient only) (if present)

40. Row ID (when necessary: provides linkage to Revenue Code Dataset)

Section 1010.Appendix F: State Inpatient Database (SID) Data Elements

1. Age in years at admission

2. Age in days (when age < 1 year)

3. Age in months (when age < 11 years)

4. Admission month

5. Admission source (uniform)

6. Admission type
7. Admission day is a weekend
8. Room and board charges
9. Ancillary charges
10. Anesthesiology charges
11. Pharmacy charges
12. Radiology charges
13. Clinical lab charges
14. Labor-delivery charges
15. Operating room charges
16. Oncology charges
17. Other charges
18. Died during hospitalization
19. Disposition of patient (uniform)
20. Discharge quarter
21. DRG in effect on discharge date
22. Data source hospital identifier
23. Principal diagnosis
24. Up to 24 secondary diagnoses
25. CCS: principal diagnosis

26. CCS: up to 24 secondary diagnoses

27. Indicator of sex

28. Length of stay (as received from source)

29. MDC in effect on discharge date

30. Number of diagnoses on this record

31. Number of procedures on this record

32. Primary expected health plan identifier (uniform)

33. Secondary expected health plan identifier (uniform)

34. Principal procedure code (if present)

35. Up to 24 secondary procedure codes (if present)

36. CCS: principal procedure (if present)

37. CCS: up to 24 secondary procedures (if present)

38. Total charges (as received from source)

39. Calendar year of discharge

40. Patient zip code (uniform)

41. Patient county code (uniform)

43. Newborn birth weight in grams

44. Do Not Resuscitate (DNR)

45. Hospitalization employment related

46. Admitting diagnosis code

47. Diagnosis present at admission for each diagnosis code

48. Ecodes (up to three if present)

49. Number of days between admission and primary procedure (if present)

50. Row ID (when necessary: provides linkage to Revenue Code Dataset)

Section 1010.Appendix G: State Ambulatory Surgery Database (SASD) Data Elements

1. Age in years at admission/visit

2. Age in days (when age < 1 year)

3. Age in months (when age < 11 years)

4. Admission/visit month

5. Admission/visit source (uniform)

6. Admission/visit type

7. Admission/visit day is a weekend

8. Anesthesiology charges

9. Pharmacy charges

10. Radiology charges

11. Clinical lab charges

12. Operating room/surgical suite charges

13. Oncology charges

14. Other charges

15. Disposition of patient (uniform)

16. Discharge quarter

17. Data source hospital identifier

18. Principal diagnosis

19. Up to 24 secondary diagnoses

20. CCS: principal diagnosis

21. CCS: up to 24 secondary diagnoses

22. Indicator of sex

23. APC code

24. Body System affected by condition/injury

25. Number of diagnoses on this record

26. Number of procedures on this record

27. Primary expected health plan identifier (uniform)

28. Secondary expected health plan identifier (uniform)

29. Principal procedure code (if present)

30. Up to 24 secondary procedure codes (if present)

31. CCS: principal procedure (if present)

32. CCS: up to 24 secondary procedures (if present)

33. Total charges (as received from source)

34. Calendar year of discharge

35. Patient zip code (uniform)

36. Patient county code (uniform)

37. Race

38. Ethnicity

39. Hospitalization employment related

40. State of accident

41. Reason for visit

42. Ecodes (up to 3 if present)

43. Row ID (when necessary: provides linkage to Revenue Code Dataset)

Section 1010.Appendix H: Revenue Code Dataset (RCD) Data Elements

1. Row ID (provides linkage to primary file)

2. Revenue Code

3. HCPCS Code (when available: outpatient only)

4. Date of Service (when available: outpatient only)

5. Units of Service

6. Charge

7. Revenue Type

8. Revenue Category

9. Submission Type (Inpatient or Outpatient)

Section 1010.Appendix I: Data Product Price List

Data Product Price List				
	Inpatient Data 1987-Present		**Outpatient Data [available only to researchers, Illinois educational institutions, and Illinois governmental entities] 2002-Present**	
Product	**Per Quarter**	**Per Year**	**Per Quarter**	**Per Year**
Category I: Resellers (Customers for Resale or Redistribution)				
Universal Dataset	$8,000	$24,000	n/a	n/a
State Inpatient Database (SID)	$8,000	$24,000		
State Ambulatory Surgery Database (SASD)			n/a	n/a
Custom Dataset (Complex)	$8,000	$24,000	n/a	n/a
Custom Dataset (Simple)	$1,000 + App fee + costs	$3,000 + App fee + costs	n/a	n/a
Revenue Code Dataset Inpatient : 1993-Present	$3,000	$8,000	n/a	n/a
HCUP/AHRQ		$24,000		n/a
Category II: Commercial/Private/Non-IL Govt/For-Profit Customers with no Resale or Redistribution				

Data Product Price List				
	Inpatient Data 1987-Present		**Outpatient Data [available only to researchers, Illinois educational institutions, and Illinois governmental entities] 2002-Present**	
Product	**Per Quarter**	**Per Year**	**Per Quarter**	**Per Year**
Universal Dataset	$4,000	$12,000	n/a	n/a
State Inpatient Database (SID)	$4,000	$12,000		
State Ambulatory Surgery Database (SASD)			n/a	n/a
Custom Dataset (Complex)	$4,000	$12,000	n/a	n/a
Custom Dataset (Simple)	$500 + App fee + costs	$1,500 + App fee + costs	n/a	n/a
Revenue Code Dataset Inpatient : 1993-Present	$1,500	$4,000	n/a	n/a
Category III: Non-Profit/ Edu Inst/ College Student Non-IL Inst Customers with no Resale or Redistribution				
Research Oriented Dataset	$1,500	$4,500	$1,000	$3,000
Universal Dataset	$1,500	$4,500	$1,000	$3,000
State Inpatient Database (SID)	$1,500	$4,500		
State Ambulatory Surgery Database (SASD)			$1,000	$3,000
Custom Dataset (Complex)	$1,500	$4,500	$1,000	$3,000
Custom Dataset (Simple)	App fee + costs	App fee + costs	App fee + costs	App fee + costs
Revenue Code Dataset Inpatient : 1993-Present Outpatient : 2004-Present	$500	$1,500	$300	$1,000

Data Product Price List				
	Inpatient Data 1987-Present		**Outpatient Data [available only to researchers, Illinois educational institutions, and Illinois governmental entities] 2002-Present**	
Product	**Per Quarter**	**Per Year**	**Per Quarter**	**Per Year**
Category IV: IL Gen Assem/IL Exec Off/IL Const Off/IL and Local Govt/College Student IL Inst Customers with no Resale or Redistribution				
UDS, SID, SASD, RCD and Custom Dataset	No Fee	No Fee	No Fee	No Fee

Section 1010.Appendix J: Data Product Preparation Cost Table

Resource	Hours/Units	Cost per Unit
Programming	1+	$100
Research	1+	$65
Administration	2	$25
Media (cd-rom/dvd-rom)	1+	$5
Shipping	1	Shipper listed cost