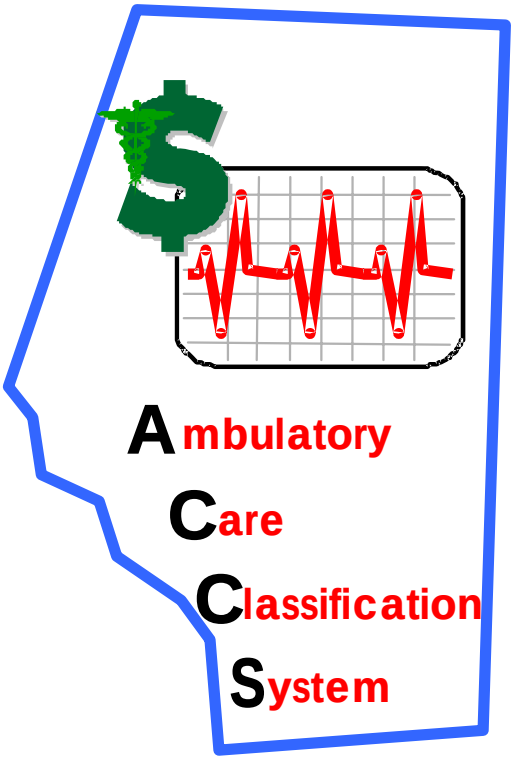
Alberta



Alberta Ambulatory Care Reporting Manual

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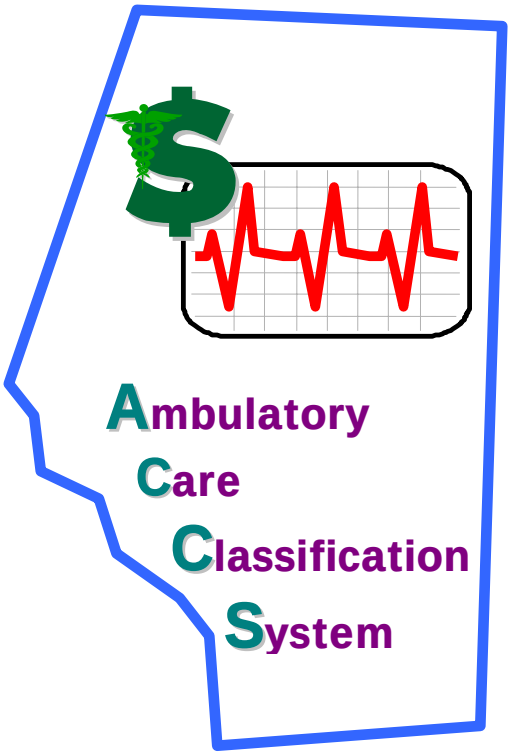

For additional copies of this manual, contact:

Alberta Health and Wellness
Health Authority Funding and Financial Accountability
19th Floor, 10025 Jasper Avenue
Edmonton, Alberta, Canada T5J 1S6
Phone: 780-427-7040
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Effective April 2008

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Alberta Ambulatory Care Reporting Manual

Introduction

Background

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

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

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

Purpose of the Manual

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

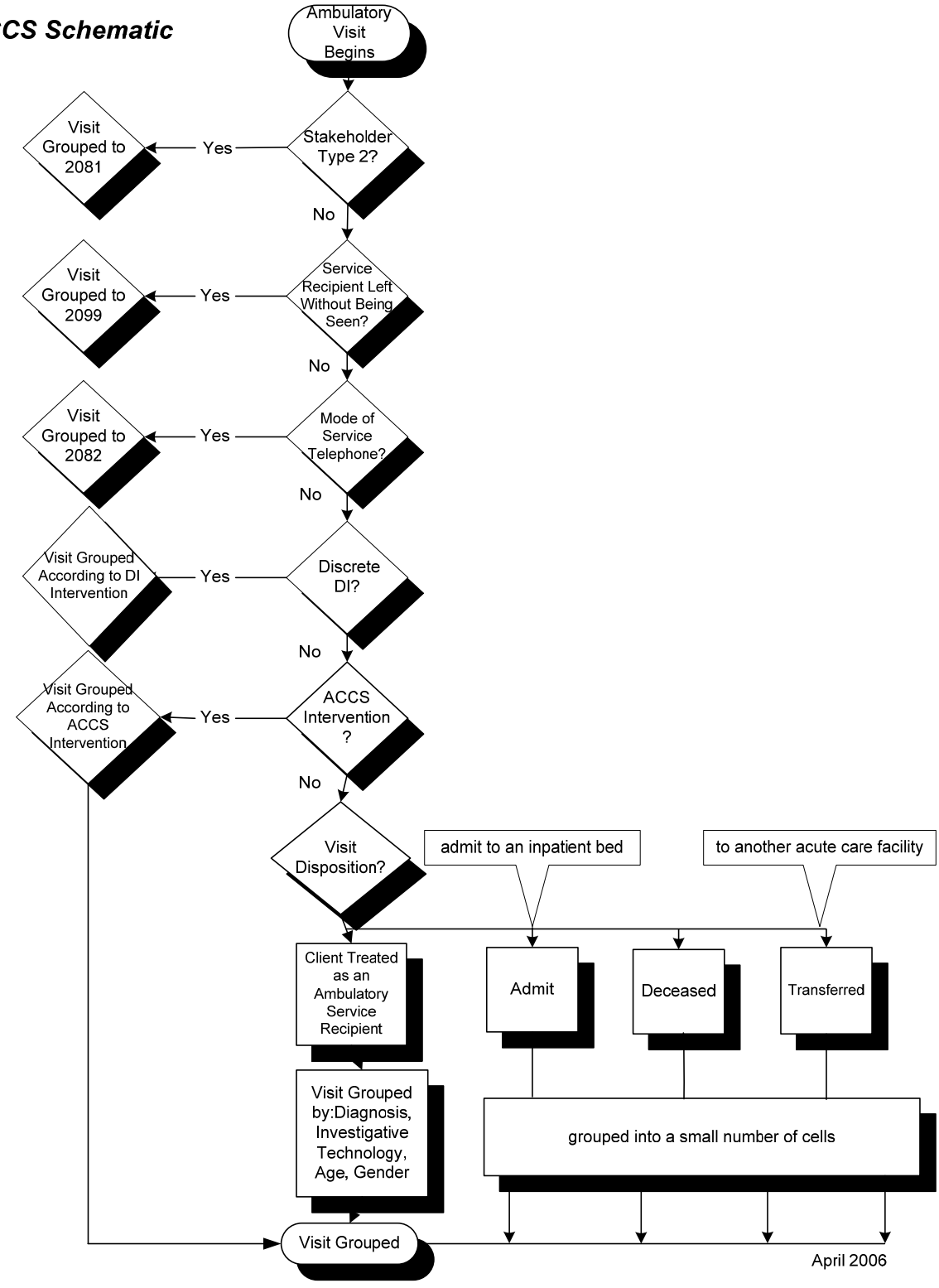
In addition to the data elements, a fairly extensive listing of coding standards and reporting examples are provided. As well, Sections 1 – 8 outline:

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

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

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

ACCS Schematic



Data Set

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

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

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

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

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

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

ALBERTA AMBULATORY CARE MINIMUM DATA SET ELEMENTS

Revised: April 2007

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

MANDATORY ACCS GROUPER DATA ELEMENTS	REQUIRED FOR GROUPING	COMMENTS
16. Provider Type		• Mandatory for mental health services, emergency and day surgery recipients; and videoconference visits when professional services paid for by the health region are provided; optional for all others
17. MIS Primary Code		• Identifies the functional centre for which an ambulatory care service is being reported
18. Mode of Service	✓	• Indicates service is provided face to face, off site, in group therapy, etc.
19. Disposition	✓	• Identifies service recipient's type of separation
20. Diagnosis Prefix		• Blank or Q for questionable or query diagnosis
21. Main Ambulatory Care Diagnosis	✓	• Diagnosis condition, problem or intervention that is the main reason for the visit • For multiple diagnoses, the diagnosis responsible for the greatest use of resources
22. Secondary Diagnoses	✓	• Conditions or problems influencing a service recipient's treatment – maximum of 9 occurrences
23. Anaesthetic Type	✓	• Indicates general, spinal, epidural, etc. • mandatory to report only for day surgery visits.
24. Main Intervention	✓	• Identifies intervention performed considered to be most clinically significant
25. Other Interventions	✓	• Maximum of 9 occurrences
26. Intervention Attributes	✓	• Used to further specify an intervention
27. Out of Hospital Indicator	✓	• Indicates interventions performed during the current visit but carried out at another site
28. Triage Level		• Applicable only to service recipients seen in an Emergency Department or a Community Urgent Care Centre

OPTIONAL ACCS GROUPER DATA ELEMENTS	COMMENTS
29. Number of Previous Term Deliveries for Therapeutic Abortion Cases	• Number of previous full term deliveries
30. Number of Previous Pre-Term Deliveries for Therapeutic Abortion Cases	• Number of previous pre-term deliveries
31. Number of Previous Spontaneous Abortions for Therapeutic Abortion Cases	• Number of previous spontaneous abortions
32. Number of Previous Therapeutic Abortions for Therapeutic Abortion Cases	• Number of previous legal therapeutic abortions

OPTIONAL ACCS GROUPER DATA ELEMENTS	COMMENTS
33. Gestational Age for Therapeutic Abortion Cases	• The gestational age, reported in weeks
34. Date of Last Menses for Therapeutic Abortion Cases	• Date of last menses
35. Triage Date	• Applicable only to service recipients seen in Emergency Department • YYYYMMDD • As of April 1st, 2006 triage date is mandatory to report for urban hospitals
36. Triage Time	• Applicable only to service recipients seen in Emergency Department • HHMM • Time service recipient triaged • As of April 1st, 2006 triage time is mandatory to report for urban hospitals
37. Registration Time	• HHMM • Time service recipient registered at facility • Mandatory to report for emergency and day surgery visits
38. Date of Physician Initial Assessment	• Applicable only to service recipients seen in Emergency Department • YYYYMMDD
39. Time of Physician Initial Assessment	• Applicable only to service recipients seen in Emergency Department • HHMM • Time when the first physician initially assesses the service recipient
40. Date Visit Completed	• YYYYMMDD • Mandatory to report for emergency and day surgery visits
41. Disposition Time	• HHMM • Time service provider discharges service recipient • Mandatory to report for emergency and day surgery visits
42. Residence Name	• First seven letters or mandatory abbreviation of the name of the place of residence of the service recipient
43. Doctor Type	• Describes role of physician associated with service recipient
44. Doctor Service	• Reflects level of training or specialty of physician
45. Chart Number	• Aids in service recipient health record identification
46. Referral Source	• Identifies the type of person or agency making the referral
47. Referred-to Agency	• Identifies the type of person or agency to which a service recipient is referred to

OPTIONAL ACCS GROUPER DATA ELEMENTS	COMMENTS
48. Stakeholder Type	• Identifies whether the stakeholder is a person or an organization
49. Coder Number	• The number identifying the person responsible for completing the record reported
50. Record Type	• Identifies type of record within data submission
51. Fiscal Year	• Represents the year the fiscal year concludes in
52. Site Code	• Identifies the exact site where services are provided
53. Service Event Number	• Used for internal facility identification of services event
54. Encounter Number	• Facilitates internal tracking of service event episode

Progress Report

Ambulatory care data collection has increased from 2002-03 to 2006-2007. Regional Health Authorities have indicated they are collecting and submitting close to 100% of their ambulatory care activity to Alberta Health and Wellness. The following table lists the changes in data submissions on a regional basis from 2002-03 to 2006-07.

Ambulatory Care Data - Number of Records Submitted by Regional Health Authority (RHA)

RHA	2002-03 Records Submitted	2003-04 Records Submitted	2004-05 Records Submitted	2005-06 Records Submitted	2006-07 Records Submitted	Change Over 2005-06	% Change 2005-06
Chinook	320,425	315,801	327,515	333,471	319,681	(13,790)	-4.1%
Palliser	185,067	196,607	200,919	228,561	229,215	654	0.3%
Calgary	1,696,926	2,161,711	2,182,929	2,147,515	2,164,171	16,656	0.8%
David Thompson	535,854	550,185	562,588	583,170	590,937	7,767	1.3%
East Central	208,483	216,256	216,353	215,622	201,070	(14,552)	-6.7%
Capital	2,385,485	2,457,982	2,480,656	2,497,992	2,526,789	28,797	1.2%
Aspen	419,246	406,795	421,919	446,520	419,667	(26,853)	-6.0%
Peace	349,963	358,516	342,223	329,988	306,985	(23,003)	-7.0%
Northern Lights	127,438	137,090	154,351	107,603	168,221	60,618	56.3%
Total Annual Records[1]	**6,228,887**	**6,800,943**	**6,889,453**	**6,890,442**	**6,926,736**	**36,294**	**0.5%**
% Change		9.2%	1.3%	0.0%	0.5%		
Active Population[2]	**3,123,744**	**3,164,405**	**3,209,513**	**3,275,376**	**3,384,046**		
% Change		1.3%	1.4%	2.1%	3.3%		

[1]Source: Morbidity and Ambulatory Care Abstract Reporting
[2]Source: Alberta Health Care Insurance Plan Registry

Ambulatory Care Reporting Contacts

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

- Provincial Ambulatory Care Advisory Group (PACAG)
- Health Information Management Advisory Committee (HIMAC)

An updated list of the committees' membership and contact information will be maintained and can be viewed with the ACCS Manual 2008 files on the Alberta Health and Wellness website.
To download the list, go to http://www.health.gov.ab.ca/. Under News/Media/Resources select Publications. Next go to Ambulatory Care and Alberta Ambulatory Care Reporting Manual 2008.

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

Policy Issues	Habib Fatoo Kasia Kunikiewicz	habib.fatoo@gov.ab.ca kasia.kunikiewicz@gov.ab.ca
Technical Issues or Clarification	Kasia Kunikiewicz	kasia.kunikiewicz@gov.ab.ca
Ambulatory Care Coding Questions	Sharilyn Kmech	sharilyn.kmech@gov.ab.ca
Website Issues	Brent Hudyma	brent.hudyma@gov.ab.ca

Tab:

Visit Examples & Coding Standards

Visit Definitions

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

Valid codes for clinical data reporting are 713 and some 714 and 715 codes in the Alberta MIS - Primary Chart of Accounts, (see Section 6). There are two exceptions to this standard:

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

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

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

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

WHO SHOULD USE MENTAL HEALTH INTERVENTION CODES: The mental health intervention codes identified in Section 3 of this manual are to be used when care is provided out of an organized mental health program to a mental health service recipient.

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

Visit Examples – Ambulatory Care

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

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

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

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

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

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

Visit Examples & Coding Standards

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

A service recipient may visit more than one ambulatory care service area within a 24 hour period. Separate visits must be reported for each area providing service recipient care unless diagnostic services included in MIS functional centres 71415 (Diagnostic Imaging), 71425 (Electrodiagnosis), and 71430 (Other Diagnostic Laboratories) are performed in conjunction with another ambulatory care visit. In those cases, the services are reported as part of the related ambulatory care visit (i.e. are not reported as an additional visit). Reporting "stand alone" visits to areas with an MIS code starting with 71425 or 71430 are optional to report if services performed are not listed as ACCS interventions in Section 5.

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

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

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

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

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

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

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

Visit Examples – Ambulatory Care

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

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

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

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

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

Report four visits.

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

Visit Examples – Ambulatory Care

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

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

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

Report three ambulatory care visits.

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

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

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

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

Report one ambulatory care visit.

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

Report two visits.

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

Report two visits.

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

Visit Examples – Ambulatory Care

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

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

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

This is considered an ambulatory care visit.

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

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

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

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

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

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

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

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

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

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

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

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

Visit Examples – Ambulatory Care

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

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

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

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

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

This is not considered an ambulatory visit.

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

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

This is considered an ambulatory care visit.

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

Visit Examples – Ambulatory Care

7a. Telephone Visits

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

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

Report one visit.

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

Report one visit.

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

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

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

Visit Examples – Ambulatory Care

7b. Videoconference (Telehealth) Visits

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

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

Examples:

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

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

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

Report two visits (Provider type must be entered).

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

The two visits are optional to report (Provider type fields must be left blank).

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

Report two visits, including one Discrete DI visit for the site where the service recipient was located and a videoconference visit (Provider type field must be entered) for the site where the radiologist providing guidance was located.

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

Visit Examples – Ambulatory Care

8. Service Recipient Seen By Physician In Consultation

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

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

Report one visit.

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

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

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

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

Report one visit.

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

Visit Examples – Ambulatory Care

10. Clinical Lab Procedures

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

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

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

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

Visit Examples – Ambulatory Care

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

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

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

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

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

At Hospital A, report an ambulatory care visit.

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

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

If the service recipient is not registered as an Emergency patient, only one visit is reported using the standard ambulatory care minimum data set.

Report Mode of Service category "9" – Discrete DI.

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

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

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

Visit Examples – Ambulatory Care

12. Visits for Private Clinics

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

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

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

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

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

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

Visit Examples – Mental Health Care

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

13. Data Reported On A Contact Basis

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

Report two visits on a contact basis.

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

14. Data Reported On A Visit Basis

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

Report one ambulatory care visit.

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

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

15. Use Of Mental Health Intervention Codes

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

This is a visit by a mental health service recipient. The occupational therapist would use the mental health intervention codes from Section 3 rather than the rehabilitation intervention codes from Section 3.

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

This is a visit by a non mental health service recipient. The General Practitioner would not use the mental health intervention codes from Section 3.

INTENT: **When care is provided out of an organized mental health program to a mental health service recipient, the mental health intervention codes identified in Section 3 should be used.**

Coding Standards- Diagnosis Coding

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

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

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

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

Example (i):

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

Assign the following information:

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

Example (ii):

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

Assign the following information:

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

Coding Standards - Diagnosis Coding

Example (iii):

Service recipient is seen for prophylactic vaccination for rubella.

Assign the following information:

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

Example (iv):

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

Assign the following information:

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

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

Example:

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

Assign the following information:

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

Coding Standards - Diagnosis Coding

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

Example:

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

Assign the following information:

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

III. Code and report chronic diseases and conditions treated on an ongoing basis as many times as the service recipient receives related care. The chronic disease/condition may or may not be coded as the Main Ambulatory Care Diagnosis depending upon the circumstances of the visit.

Example:

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

Assign the following information:

Code	Code Description
M06.9	Rheumatoid arthritis, unspecified site

Coding Standards - Diagnosis Coding

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

Example:

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

Assign the following information:

Code	Code Description
R10.4	Other and unspecified abdominal pain

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

Example (i):

Service recipient with obesity is seen for dietary counseling.

Assign the following information:

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

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

Coding Standards - Diagnosis Coding

Example (ii):

Cancer service recipient is seen solely for chemotherapy.

Assign the following information:

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

Example (iii):

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

Assign the following information:

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

Example (iv):

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

Assign the following information:

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

Coding Standards - Diagnosis Coding

Example (v):

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

Assign the following information:

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

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

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

The assignment of Respiratory Therapy to Z50.9 Care involving use of rehabilitation procedure, unspecified allows this rehabilitation discipline to remain distinct for reporting purposes.

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

Example:

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

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

Coding Standards - Diagnosis Coding

Assign the following information:

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

Note: All Discrete Diagnostic Imaging visits should have Z01.6 reported as the Main Ambulatory Care Diagnosis.

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

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

Example:

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

Assign the following information:

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

Coding Standards - Diagnosis Coding

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

Updated: April 1, 2008

If the original condition is found to have recurred during the follow-up visit:

- Assign the diagnosis code reflecting the recurrent condition as the Main Ambulatory Care Diagnosis.
- It is mandatory to assign a diagnosis code from Z08^^ or Z09^^ as a secondary diagnosis.
- It is mandatory to assign a diagnosis code indicating the personal history of the condition as a secondary diagnosis.

If the original condition has not recurred:

- Assign a diagnosis code from Z08^^ or Z09^^ as the Main Ambulatory Care Diagnosis.
- It is mandatory to assign a diagnosis code indicating the personal history of the condition as a secondary diagnosis.
- It is optional to assign a diagnosis code for any incidental findings, if identified, as a secondary diagnosis.

Example:

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

Assign the following information:

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

Coding Standards - Diagnosis Coding

Example:

Service recipient 3-years post-mastectomy is seen for routine check. Recurrence of malignant neoplasm of breast is found.

Assign the following information:

Code Sequence	Code	Code Description
1	C50.99	Malignant neoplasm of breast, part unspecified, unspecified side
2	Z08.0	Follow-up examination after surgery for malignant neoplasm (mandatory)
3	Z85.3	Personal history of malignant neoplasm of breast (mandatory)

Coding Standards - Injury Coding Updated April 1, 2008

Current Injury

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

Select the current injury code as the Main Ambulatory Care Diagnosis on all subsequent admissions for treatment of the original injury. This may involve a multi-stage treatment plan.[3]

Aftercare

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

Additional diagnosis code(s) from S00.0 to T78.9, Injury, poisoning and certain other consequences of external causes may be added as additional optional secondary diagnosis code(s) to describe the original injury. The external cause code should not be assigned.

Follow-up

Surveillance only following completed treatment.

Late Effect

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

An additional diagnosis code from T900 to T983, Sequelae of injuries, of poisoning and of other consequences of external causes may be added as an additional optional secondary diagnosis to describe the original injury.

Old/Non Current

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

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

[3] Canadian Institute for Health Information, *Canadian Coding Standards for ICD-10-CA and CCI for 2008* (Ottawa: CIHI, 2007), pages 260-262.

Coding Standards - Injury Coding Updated April 1, 2008

Examples of Injury Coding

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

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

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

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

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

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

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

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

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

Coding Standards - Injury Coding Updated April 1, 2008

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

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

   An additional diagnosis code(s) from S00.0 to T78.9, Injury, poisoning and certain other consequences of external causes may be added as an optional secondary diagnosis code to describe the nature of the original injury. The external cause code should not be assigned.

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

   An additional diagnosis code(s) from S00.0 to T78.9, Injury, poisoning and certain other consequences of external causes may be added as an optional secondary diagnosis code to describe the nature of the original injury. The external cause code should not be assigned.

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

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

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

Coding Standards - Intervention Coding

Intervention Definition

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

Fundamental Standards For Coding Interventions

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

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

Assign the following information:

Code	Code Description
1.CL.89.VR-LN	Excision total, lens phacoemulsification with posterior chamber rigid lens prosthesis inserted

Coding Standards - Intervention Coding

Example (ii):

Service recipient admitted for dilatation and curettage and subsequent endoscopic bilateral tubal ligation.

Assign the following information:

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

Example (iii):

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

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

CANCELLED is reported for day surgery interventions only.

Updated: April 1, 2008:

For cases where the intended intervention is abandoned after administration of anaesthesia, incision, inspection or biopsy, assign the code for the anaesthesia, incision, inspection or biopsy followed by the code for the intended intervention with the status attribute “A” indicating abandoned.

When a day surgery intervention is cancelled due to a contraindication, assign a diagnosis code from Z53^ Persons encountering health services for specific procedures, not carried out.

- If the condition or contraindication does not receive treatment, assign Z53^ Persons encountering health services for specific procedures, not carried out as the Main Ambulatory Care Diagnosis. Assign code(s) for the condition and/or contraindication as additional secondary diagnosis code(s).
- If the reason for admission or another condition fulfills the criteria for Main Ambulatory Care Diagnosis, code the reason for admission or the condition as the

Coding Standards - Intervention Coding

Main Ambulatory Care diagnosis followed by the code from Z53^ Persons encountering health services for specific procedures, not carried out as an additional secondary diagnosis.

STANDARDS FOR ASSIGNING Z CODES FOR AMBULATORY CARE ACTIVITY

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

Z codes, the classification of **Factors influencing health status and contact with health services**, are provided to deal with visits when circumstances other than a disease or injury classifiable to categories A00.0 through Y89.9 are recorded as reasons for encounters with a service provider.

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

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

1. Contact/exposure

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

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

2. Immunizations

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

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

3. *Status*

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

The status Z code/categories include:

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

Categories Z89 and Z93-Z99 are for use only if there are no complications or malfunctions of the organ or tissue replaced, the amputation site, or the equipment on which the service recipient is dependent. These are usually secondary codes.

4. History (of)

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

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

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

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

The history Z codes/categories include:

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

5. SCREENING *Updated: April 1, 2008*

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

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

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

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

When the original condition or a condition related to the reason for screening is found on examination:

- The diagnosis code for the condition is assigned as the Main Ambulatory Care Diagnosis.
- A diagnosis code from Z11^^, Z12^^, Z13^^ or Z36^^ is assigned as a mandatory secondary diagnosis code.
- A diagnosis code describing the reason for the screening, such as family history, is assigned as a mandatory secondary diagnosis code.
- Incidental findings unrelated to the reason for the screening are added as an optional secondary diagnosis code(s).

If the condition related to the reason for screening is not found on examination:

- A diagnosis code from Z11^^, Z12^^, Z13^^ or Z36^^ is assigned as the Main Ambulatory Care Diagnosis.
- A diagnosis code describing the reason for the screening, such as family history, is assigned as a mandatory secondary diagnosis code.
- Incidental findings unrelated to the reason for the screening are added as an optional secondary diagnosis code(s).

The screening Z code categories include:

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

6. OBSERVATION *Updated: April 1, 2008*

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

The observation Z code category is:

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

7. AFTERCARE

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

The aftercare Z code categories include:

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

8. FOLLOW-UP *Updated: April 1, 2008*

The follow-up codes are used to explain surveillance following **completed** treatment of a disease, condition, or injury.

If the original condition is found to have recurred during the follow-up visit:

- Assign the diagnosis code reflecting the recurrent condition as the Main Ambulatory Care Diagnosis.
- It is mandatory to assign a diagnosis code from Z08^^ and Z09^^ as a secondary diagnosis.
- It is mandatory to assign a diagnosis code indicating the personal history of the condition as a secondary diagnosis.

Visit Examples & Coding Standards

If the original condition has not recurred:

- Assign a diagnosis code from Z08^^ and Z09^^ as the Main Ambulatory Care Diagnosis.
- It is mandatory to assign a diagnosis code indicating the personal history of the condition as a secondary diagnosis.
- It is optional to assign a diagnosis code for any incidental findings, if identified, as a secondary diagnosis.

The follow-up Z code categories include:

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

9. DONOR

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

10. COUNSELING

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

The counseling Z codes/categories include:

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

11. CONTRACEPTION, PROCREATION, OBSTETRICS, AND RELATED CONDITIONS

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

Visit Examples & Coding Standards

Z code/categories for this section include:

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

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

12. NEWBORN, INFANT, AND CHILD

Newborn Z codes/category include:

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

13. ROUTINE AND ADMINISTRATIVE EXAMINATIONS

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

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

Visit Examples & Coding Standards

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

Z00^^	General examination and investigation of persons without complaint and reported diagnosis
Z00.1	Routine child health examination
Z01^^	Other special examinations and investigations of persons without complaint or reported diagnosis (Note: Z01.6, Z01.7 and Z01.8 may also be assigned to visits for examinations for diagnosis of a suspected condition.)
Z02^^	Examination and encounter for administrative purposes
Z10^^	Routine general health check-up of defined subpopulation

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

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

15. ADDITIONAL Z CODES

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

Additional Z code/categories include:

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

Tab:

Summary of Reporting Recommendations 1997/1998 to 2007/2008

Summary of Reporting Recommendations 1997/1998 to 2007/2008

Section I. Ambulatory Care Reporting Recommendations Resulting From Discussions at Provincial Ambulatory Care Advisory Group Meetings

PACAG Meeting Date	Subject	Recommendation
Oct 25/2007	Disposition	An emergency room service recipient is admitted as inpatient but remains in emergency holding area (EIP). He/she is subsequently transferred to the OR or CCU. What disposition should be reported for the emergency room visit? Discharge disposition from ER should be based on intent at time of discharge – if being discharged to OR but sent to EIP first before OR ready, disposition code 4 (Service recipient admitted as an inpatient to Critical Care Unit or OR in own facility) would apply. If discharged from ER to EIP where intent was to admit to the facility (not to CCU/OR), disposition code 5 (Service recipient admitted to another area in own facility) would apply regardless of patient movement or change once in the EIP (inpatient status).
Oct 20/2006	Telehealth	If a service recipient at Site A is seen face to face by a physiotherapist and a respiratory therapist for the first part of the session and in the second part of the session, the service recipient and the two therapists are joined by therapists from Site B via teleconference, Site A should report 4 visits. 2 visits are reported for the clinical providers who are diverse. Since each provider changes mode of service from face to face to videoconference, another 2 visits should be reported (2*2=4).
Oct 20/2006	ER - Pre-Op - Day Surgery transfers	If a service recipient is admitted to ER, is transferred to Pre-Op for additional pre-operative work and then to Day Surgery, two visits should be reported, one for the ER and one for the Day Surgery.

PACAG Meeting Date	Subject	Recommendation
Oct 20/2006	DOA and DAA reporting	<u>When is disposition of "DOA" assigned?</u> • Usually no resuscitative efforts are made (on rare occasions resuscitative efforts may be made for compassionate reasons); and/or • Based on physician documentation. Continue to use the above criteria for DOA assignment. In case of a discrepancy between the status assigned by the physician and chart documentation (e.g. physician assigned a status of DOA but ECG strips provide evidence of heart rhythm), the disposition should be assigned based on physician documentation. <u>When is disposition of "DAA" assigned?</u> • Usually resuscitative efforts are made (e.g. CRP); and/or • Based on physician documentation Continue to use the above criteria for DAA assignment. In case of a discrepancy between the status assigned by the physician and chart documentation, the disposition should be assigned based on physician documentation. <u>Other recommendations on DOA/DAA reporting:</u> • Visits for DOA patients brought in to a facility for further resuscitation and for declaration of death by a physician should be reported to AHW. • Visits for bodies brought in to a facility strictly for examination by medical examiner, to be prepared for identification and for storage purposes (e.g., to be held for pick up by a funeral home) should not be reported to AHW. It is a regional/ facility business decision whether these bodies are registered or not. • If a DOA patient is brought in with the attempt to resuscitate, cause of death should be coded as main diagnosis. If there is no documentation on cause of death, R960 (Instantaneous death), R961 (Death occurring less then 24 hours from onset of symptoms, not otherwise explained) R98 (Unattended death), or R99 (Other ill-defined and unspecified causes of mortality) may be coded as main diagnosis. • If a DOA patient is brought in for declaration of death by a physician, Z02.7 (Issue of medical certificate) should be coded as main diagnosis and the cause of death, if documented, should be coded as secondary diagnosis. • Interventions may be code if resuscitative attempts are made to a DOA patient.

PACAG Meeting Date	Subject	Recommendation
June 09/2006	Provider type	For services provided by a cross-trained PT/OT aid report a provider type that reflects the type of service he/she performs most frequently. For example, if the cross-trained PT/OT aid provides services as a PT aid more frequently than an OT aid, report the PT aid provider type code.
Sep 29/2005	Doctor number	If the anaesthetist/ radiologist is the physician considered the most responsible for the care of the service recipient, then their doctor number should be reported in the first doctor number occurrence. If the anaesthetist/ radiologist see the service recipient in their own capacity (i.e. to administer an anesthetic/ to perform a DI exam), their doctor number should not be reported.

PACAG Meeting Date	Subject	Recommendation
Sep 29/2005	Diverse services provided by the same provider type	If the same service provider provides a range of services within one MIS functional centre, only one visit is reported. Example: A nurse, who is paid out of the MIS functional centre of Diabetes Clinic, provides instruction on insulin injection and also changes a wound dressing. Only one visit would be reported. If different service providers of the same discipline, from the same MIS functional centre, provide a range of services to the same service recipient during a trip to a healthcare facility, only one visit is reported. Example: A nurse, who is paid out of the MIS functional centre of Diabetes Clinic provides instruction on insulin injection. Another nurse, also paid out of the Diabetes Clinic functional centre changes a wound dressing. Only one visit would be reported. If different service providers of the same discipline, but from different MIS functional centres, provide a range of services to the same service recipient during a trip to a healthcare facility, a visit is reported for each service provider. Example: A nurse, who is paid out of the MIS functional centre of Renal Clinic provides a patient service. A nurse, who is paid out of the MIS functional center of Diabetes Clinic also provides a patient service. Two visits would be reported. If the same service provider provides a range of services paid out of different MIS functional centres, a visit is reported for each service. Example: A nurse, who is paid out of the MIS functional centre of Renal Clinic provides a patient service related to renal dialyses. The same nurse is also paid out of the MIS functional centre of Diabetes Clinic and provides a patient service related to diabetic care. The service recipient may or may not move between clinics. Two visits would be reported.
Sep 29/2005	Mode of contact - e-mail	E-mails are not considered reportable ACCS visits.
Sep 29/2005	Multiple visits to therapist	If the mode of service does not change and the intent is to continue on with the service that has not been completed, even if the service recipient leaves the facility, only one visit should be reported. Note: This is different from a scenario in which a service recipient presents to emergency department, is seen by the nurse, is told that the doctor will be able to see him in X hours and is asked to return at that time. In this scenario two visits would be reported.

PACAG Meeting Date	Subject	Recommendation
Sep 29/2005	Discrete DI	If a service recipient comes in for a discrete DI and after receiving the DI visits the emergency room for an unrelated condition, two visits should be reported, one for discrete DI (with mode of service "9") and one for the emergency room visit.
May 27/2005	Visit end date	Visit end date is mandatory to report for emergency and day surgery visits.
May 27/2005	Ambulatory care provided to inpatients	If an inpatient at site A receives ambulatory care services from a health care provider from site B (the provider traveled to site A to provide the services), these services should be reported on the inpatient abstract only and should not be reported in ACCS.
May 27/2005	Returning ER patients	If a service recipient presents to an emergency department, is seen by the nurse and is told that the doctor will be able to see him in X hour(s) and the patient returns in X hour(s) to see the doctor, two visits should be reported. Note: A new disposition code (no doctor available, service recipient asked to return later) will be added for 2006/07. The first visit will have to be reported with the new disposition code effective April 1st, 2006. For the remainder of 2005/06, report two visits with disposition codes that are currently available.
May 27/2005	Telehealth	If a service recipient at site A receives a telehealth service from site B, report Mode of Service 4 (Videoconference) at both sites.
Jan 28/2005	ULI reporting	In cases where available service recipient information does not facilitate looking up a ULI in Person Directory or issuing a ULI, nine zeros (000000000) must be reported as the ULI. The ULI field should not be left blank in these situations.
Sep 24/2004	Triage level reporting	At the January 23, 2004 PACAG Meeting, AHW presented options regarding mandatory reporting of triage levels (TL) in ACCS. Taking into account advantages/ disadvantages of each option and input from PACAG members, the decision was made to apply the phased-in approach with mandatory TL reporting: for large urban facilities starting April 1st, 2004; for regional facilities starting April 1st, 2005; and for rural facilities starting April 1st, 2006.
Sep 24/2004	Query diagnoses	According to Alberta coding standards (Ambulatory Care Reporting Manual 2004, pg. 24), diagnoses documented as probable must be coded with a prefix of "Q". In this case Alberta coding standards are different from CIHI's coding standards which indicate that probable diagnosis should not be reported.

PACAG Meeting Date	Subject	Recommendation
Sep 24/2004	Multiple interventions with the same CCI code	Interventions with the same CCI code may be reported multiple times per record, as long as the interventions were different. For example, there are cases in which the same CCI code is attached to different types of exam codes (MRI, inter-surgery and post-surgery). If two unique exams have been performed, the same CCI code may be reported twice for one visit.
Sep 24/2004	Telehealth	As of April 1st, 2005, it will become optional to report telehealth services with no regional service provider present. If reported, in order to identify these services, the “Provider Type” field must be left blank. Telehealth services with a regional service provider present remain mandatory to report. In order to identify these services, a provider must be entered in the “Provider Type” field.
Sep 24/2004	Home Care Service Recipients	It is recommended that: Rehabilitation services provided in a home setting to individuals who are enrolled in Home Care are to be reported in the home care reporting system, not ACCS. Other services provided in a home setting to individuals who are enrolled in Home Care are also to be reported in the home care reporting system. This includes, but is not restricted to the following services: nursing, personal care, homemaking, social work. Services provided to home care clients in an ambulatory care setting shall continue to be reported in ACCS. Specialty clinical services that are not normally provided as part of the home care program, which are provided to an individual in their home as part of the outpatient care program, are to be reported in ACCS with Mode of Service “5”.
May 31/2004	Reporting discrete DIs	For scheduled CT Scan visits where the IV, which is required to perform the examination, is inserted in the Emergency Department, one discrete diagnostic imaging investigation visit should be reported.
May 31/2004	Institution numbers and satellite offices	Some ambulatory service recipients (e.g. renal patients) receive services at one facility (facility A) but the services are co-ordinated and funded through a cost centre from another facility (facility B). Activity is reported in ACCS under facility B. According to the reporting guidelines the institution number “should be the delivery organization that is responsible for the provision of services to service recipients".
Sep 19/2003	Abandoned interventions	In the case of an abandoned intervention, the intervention should not be reported as completed.

PACAG Meeting Date	Subject	Recommendation
June 20/2003	Coder number	A new optional field called “Coder Number” will be included into the ACCS file layout for 2004/2005 data year.
June 14/2002	CCI interventions	All CCI codes in Section 4 of the Ambulatory Care Reporting Manual are mandatory to report.
April 26/2002	Student as provider	Ambulatory care services with a student as the only provider should be reported through ACCS.
April 26/2002	Provider type	If a unique provider type does not exist for service providers, the provider type 09999 may be assigned or the RHA may develop a unique number to identify the provider. If the latter approach is chosen, this number must not be provided to AHW, as an error message will be generated. The number may be transferred to a valid Provider Type number or not submitted to AHW if reporting Provider Type is not mandatory for the visit.
April 26/2002	Doctor number	Anaesthesiologists should not be reported in doctor number field if they are seeing the service recipient in an anaesthesiologists capacity.
April 26/2002	Anaesthetic type	All day surgery interventions must be reported with an anaesthetic type. If no anaesthetic was administered, report “8” (No anaesthetic). Reporting anaesthetic type for other interventions is optional.
April 26/2002	Cancelled interventions	Report “CANCELLED” in the CCI code field for cancelled day surgery interventions.
Oct 12/2000	Rehabilitation interventions	Interventions reported for rehabilitation disciplines should reflect the time spent by the service provider with the service recipient (not the time of the service recipient spent in the service area).
Oct 12/2000	Respiratory services received in ER	If a service recipient is seen in the ER and receives Respiratory services in addition to other ER services, a separate visit should be reported for the Respiratory services.
Jan 13/2000	LTC service recipients	All services provided to a LTC service recipient, who is not registered as an ambulatory care service recipient, should not be reported as an ambulatory care visit.

PACAG Meeting Date	Subject	Recommendation
Sep 10/1999	Reporting disposition codes for mental health service recipients	In the event that two mental health service providers see a mental health service recipient (two visits), who is subsequently admitted as an inpatient, a Disposition code of 5(Admit) should be reported for one visit and a Disposition code of 1(Discharged) should be reported for the other visit. Reporting on this manner will not inflate the number of admissions as an inpatient.
May 27/1999	Community Cancer Clinics service recipients	The decision was made not to submit ambulatory care data for the Community Cancer Clinics through the ambulatory care reporting stream since this patient activity is under the jurisdiction of the Alberta Cancer Board.

Section II. Letter Regarding Reporting Visits And Attendance Days

June 26, 1998

To: Regional Ambulatory Care Coordinators
Community Rehabilitation Representatives
Chief Financial Officers

In collaboration with the work being done in the Capital Health Authority (CHA) regarding reporting visits and attendance days (please refer to the attached memo previously circulated to the Ambulatory Care Regional Coordinators), we are pleased to provide the following response to the recommendations outlined on page 3 of the memo.

The three recommendations made by CHA include:

1. **The terms "outpatient attendance day" and "ambulatory care visit" be consistent and interchangeable for all ambulatory care activity.**

Alberta Health agrees that there should be consistency between MIS statistical and ambulatory care activity reporting. Therefore, the MIS mandatory statistics have been modified to facilitate reporting using the outpatient visits definition for the therapeutic functional centres (see attached list) **or** attendance days. Please see the enclosed "Alberta MIS Mandatory Statistics Summary" for definitions. Regions need to select **one** of the reporting alternatives. Commencing with 1999/2000, it is felt that statistics should be reported using the Outpatient Visits definition.

2. **Where there are multiple ambulatory care contacts with equivalent provider types on the same date, for related services, for the same condition, regardless of the mode of service (e.g. individual, group, telephone), one visit/attendance day would be reported.**

Reporting different modes of service provides valuable information for data analysis and review of health care delivery trends. If the mode of service does not change, and the intent is to continue on with a service that has not been completed, even if the service recipient leaves the facility, only one ambulatory care visit needs to be reported.

For example, a physical therapist seeing a service recipient in the morning for assessment and providing an intended therapeutic intervention after lunch (service recipient leaves the Physical Therapy Department), would report only one ambulatory care visit. A series of IV therapy treatments provided on the same day should still be reported as separate ambulatory care visits because each treatment within the series is considered as being started and finished and not a continuation.

...2

3. The ACCS definition of a "telephone visit" be strictly adhered to when creating ambulatory care visits from telephone contacts.

As per the ambulatory care reporting guidelines, before an ambulatory care visit is reported for a telephone interaction with a service recipient or a significant other, there must be clinical documentation and the exchange of information must take the place of a face-to-face visit.

Please discuss these recommendations and their impact with stakeholders in your region and provide your feedback by **July 31, 1998** to Roman at:

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Yours truly,

Roman Sus
MIS Coordinator
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Shirley Groenen
Health Records Planner
Information Planning/Information Management

Enclosures

Section III. Letter Regarding Reporting for Rehabilitation

November 19, 1998

To: Regional Rehabilitation Representatives
Regional Ambulatory Care Coordinators
Regional Health Records Representatives

The attached information is in response to questions raised regarding ambulatory care patient activity reporting for the rehabilitation disciplines of Audiology, Physical Therapy, Occupational Therapy, Recreational Therapy, Speech Language Pathology, and Respiratory Therapy.

Answers to the questions were previously circulated on June 26, 1998. Based on feedback received from stakeholders, answers to questions 1, 5, 6, and 7 have been changed. Answers to questions 9 and 10 include additional clarification. Please apply the reporting guidelines provided in the attached responses to your 1999/2000 data submissions.

Please contact us if you have any questions regarding this information.

Yours truly,

Dee-Jay King
Health Economist
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427-7132

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Attachments

Responses To Ambulatory Activity Reporting Questions

Rehabilitation Disciplines

1. What services are included in the intervention categories of Assessment, Therapeutic Intervention, and Consultation/Collaboration?

Effective with April 1999, include time spent documenting clinical information as part of the appropriate intervention category (i.e. Assessment, Therapeutic Intervention, Consultation/Collaboration) regardless of when the documentation is completed. Reporting clinical documentation in this manner is in keeping with the National MIS Guidelines. Currently, reporting guidelines indicate that any documentation completed on a day subsequent to a service recipient being seen should be considered as a Consultation/Collaboration activity.

2. Should time spent traveling by a service provider to provide care to a service recipient be reported as a service recipient activity?

According to the MIS Guidelines travel time is classified as a non-service recipient activity. Alberta Health agrees that time spent traveling as part of a regular job requirement should not be added to Assessment or Therapeutic Intervention times. However, when travel is required in unusual circumstances (e.g. escorting a service recipient home after treatment), it would be appropriate to include the travel time in the Assessment or Therapeutic Intervention categories.

3. Is an ambulatory care service event reported when a rehabilitation service provider provides therapeutic advice to another service provider on behalf of a service recipient?

At this time, an ambulatory care service event is not reported for these scenarios. The 1999 MIS definition of significant other is “individuals who are acting on behalf, or in the interest of the service recipient such as a parent, spouse/partner, child, legal guardian or substitute decision maker. An example of this is a mother receiving information/education from a service provider regarding a home treatment program for her child. Excluded in this definition are nurses, aides, ministers, teachers, or other health service personnel.”

Alberta Health notified CIHI of regional concerns with not considering teachers, for instance, as a significant others. The issue was discussed at a national meeting of the provincial MIS Coordinators and a number of provinces strongly opposed broadening the definition of significant other. Therefore, the definition has not been changed.

4. What is the time period for linking activities included in the Consultation/ Collaboration intervention category to when the service recipient was seen by a rehabilitation service provider?

There is no set time period for linking activities. Regions should choose a time period that will result in at least 80% of their Consultation/Collaboration activity being linked to when the service recipient was or will be seen.

5. Who is responsible for collecting the ambulatory care activity if a service provider from one site provides a service to a service recipient at another site?

The service provider providing the service is responsible for collecting the ambulatory care activity and the site where the activity occurs is responsible for reporting the activity. Regions should use discretion and best judgment in applying this guideline.

6. How is time spent calling a supplier to obtain information on a device or aid for a service recipient reported? Is reporting different if the service recipient is or is not present at the time of the call?

If the service recipient is present when the phone call is made to a supplier, consider the time spent in telephone conversation as either Assessment or Therapeutic Intervention. Report the activity as Consultation/Collaboration if the service recipient is not present at the time of the call.

7. Are set-up and clean-up times related to providing treatment to a service recipient included in the Therapeutic Intervention category?

Yes, set-up and clean-up times are included in the Therapeutic Intervention category. For example, if a hot pack is to be applied, include the time required to get the hot pack, heat it, apply it, and put it away after the treatment has concluded, along with the time actually spent with the service recipient. Time spent "observing" the service recipient is not included in calculating the total Therapeutic Intervention time.

8. Is time spent e-mailing a service recipient regarding an assessment or therapeutic intervention reported as an ambulatory care service event?

No, using e-mail is not considered as direct dialoguing with the service recipient and therefore should not be reported as an ambulatory care service event. Time spent in this activity should be considered as Consultation/Collaboration and linked to an ambulatory care service event for the service recipient.

9. Should separate ambulatory care service events be reported when an occupational therapist from the Seating Clinic and an occupational therapist from the Brain Injury Clinic see a service recipient on the same day? Should separate ambulatory care service events be reported when the same occupational therapist working out of both the Seating Clinic and the Brain Injury Clinic see the same service recipient on the same day?

Yes, two ambulatory care service events should be reported for both scenarios. Multiple service events would also be reported if the same occupational therapist working out of the same functional centre provided multiple distinct services to the same service recipient.

10. What ambulatory care reporting is required when a physical therapist from one site provides treatment to a service recipient in conjunction with another physical therapist at another site?

Only one ambulatory service event would be reported including the time spent by both physical therapists in providing treatment. Please refer to the response provided for Question 5 for additional reporting information.

11. What is included in the category "Public health/community health" for the data elements of "Referral Source" and "Referred-to Agency?"

Think of this category as pertaining only to Public health which includes Immunization and Adverse Reactions, Communicable Disease Control, Maternal and Child Health, Health Promotion, Dental Health, School Health, Seniors' Programs, and Special Screening Programs. The name of this category will be changed to "Public health" in the next revision of Volume II: Alberta Ambulatory Care Minimum Data Set.

12. In the event that a service recipient is referred for rehabilitation services by a physician on the recommendation of a Home Care service provider, what should be reported as the Referral Source?

Report the person or agency making the initial referral which would be Home Care in this scenario.

13. What time is included in the Assessment and Therapeutic Intervention codes?

Only the time that is spent by the **service provider** performing activities included in these intervention categories (see Vol II: Alberta Ambulatory Care Data Set, Appendix D). It does not include the time that the service recipient was doing therapy on his or her own and therefore may be different than the total time the service recipient was in the service area.

Section IV. Visit Scenarios for Ambulatory Care - March 2000

Examples of Visits In Ambulatory Care Functional Centres Requiring Reporting

- Each visit in same or different centres.
- Visits in a centre with subsequent inpatient admission.
- Visits in a centre when a service recipient is currently an inpatient at another facility.
- Telephone/video conference visits when they replace a face to face visit and warrant clinical documentation.
- Visits where care is provided by a service provider at a service recipient's residence.
- Each service recipient contact with diverse care providers during a visit.
- Discrete diagnostic imaging visits.

Reporting Visits for Rehabilitation Service Providers

Scenario	Visits Reported	Rationale/Time Reported
Two occupational therapists treat same service recipient during a session	One	Service providers are not considered to be providing diverse care; only one visit is reported. Report the combined treatment time of both service providers.
Occupational therapist and occupational therapy aide treat same service recipient during a session	One	Service providers are not considered to be providing diverse care; only one visit is reported. Report the combined treatment time of both service providers.
Physical therapist and occupational therapist treat same service recipient during a session	Two	Service providers are considered to be providing diverse care; two visits are reported. Report the treatment time of the service providers individually. Do not combine the times.

Reporting Visits for Rehabilitation Service Providers

Scenario	Visits Reported	Rationale/Time Reported
Two recreational therapists treat six service recipients (group session) for a one-hour session	Six	Service providers are not considered to be providing diverse care; one visit would be reported for each service recipient. Divide the treatment time that each service provider spent with the group by the number of service recipients in the group. Report the combined treatment time for both service providers per service recipient. In the example provided, each therapist would have treated each service recipient for 10 minutes (60 min./6 service recipients). The total time reported by the service providers for each visit would be 20 min. (10 min. per therapist).

Reporting Visits for Rehabilitation Service Providers

Scenario	Visits Reported	Rationale/Time Reported
Recreational therapist and physical therapist treat six service recipients (group session) for a one-hour session	Twelve	Service providers are considered to be providing diverse care; two visits would be reported for each service recipient. Divide the treatment time that each service provider spent with the group by the number of service recipients in the group. Report that treatment time for each visit. Do not combine the service providers' times. In the example provided, each therapist would have treated each service recipient for 10 minutes (60 min./6 service recipients). The total time reported by each service provider per visit would be 10 min.

Note: The assignment of an intervention code from the low, medium, or high intervention categories of Assessment, Therapeutic Intervention, and Consultation/Collaboration is determined by the time spent by the **service provider** delivering services.

Scenario for Reporting Day Program Visits

Visits to Day Programs may be reported if they are not collected through another reporting stream (e.g. continuing care).

Example

A service recipient is seen in a Day Program area for recreational therapy and physical therapy.

Reporting

Report two ambulatory care visits, each with the MIS functional centre code reflecting the services provided.

Scenarios for Reporting Care Provided to Significant Others

MIS Definitions

A **service recipient** is defined as the consumer of primary service activities of one or more functional centres of the health service organization. Service recipients include individuals (e.g. inpatients, residents, clients) and their significant others, and others as defined by the health service organization.

Significant others are individuals who are acting on behalf, or in the interest of the service recipient such as a parent, spouse/partner, child, legal guardian or substitute decision maker. An example of this is a mother receiving information/education from a service provider regarding a home treatment program for her child. Excluded in this definition are nurses, aides, ministers, teachers, or other health service personnel.

Reporting Guidelines

- Care provided on behalf of the service recipient to a significant other, even though the service recipient is not present, should be reported as an ambulatory care visit.
- Care provided on behalf of the service recipient to a significant other with the service recipient present should not be reported as a separate ambulatory care visit. A visit would be reported for the service recipient.

1. **Example**
   A mother receives instructions provided by a physical therapist for a home treatment program for her child who is a registered service recipient. The child is not present at the teaching session.

   Reporting

   A visit would be reported for the mother (significant other) under the child's registration information (service recipient).

2. **Example**
   A mother receives instructions provided by a physical therapist for a home program for her child who is a registered service recipient. The child is present at the teaching session.

   Reporting

   A visit would be reported for the child (service recipient) but no separate visit would be reported for the teaching provided to the mother (significant other).

3. Example

A gentleman suffers a cerebrovascular accident and sees a physical therapist for exercise training. Meanwhile, the gentleman's wife sees a speech-language pathologist to receive instruction related to completing speech exercises with her husband at home.

Reporting

Two separate visits would be reported; one visit for the husband (service recipient) and one visit for the wife (significant other). Both visits would be reported under the service recipient's registration information.

4. Example

A speech-language pathologist meets with the teacher of a student (service recipient) to provide instruction regarding how to assist the student for a speech difficulty.

Reporting

As the teacher is not considered a significant other, by MIS definition, no ambulatory care visit is reported.

Reporting Ambulatory Care Diagnostic Imaging

Definitions

Discrete Diagnostic Imaging (DI)	Those diagnostic imaging services that are not part of an inpatient or outpatient visit; a “stand alone” visit for diagnostic imaging services only.
Outpatient Referred-in Diagnostic Imaging	Applies to procedures done for service recipients referred in from another facility or region. Service recipients must be registered in-patients or out-patients at another facility or region.
Linking Period	A time period established by the region within which 80% of diagnostic imaging activity can feasibly be attached to a previous or following visit to which it pertains.

Reporting Examples

Example	Reporting
1. Service recipient is seen in ER and a DI service is performed during the visit	Report a visit for the care received in ER. The DI service would be reported as part of the ER visit information.
2. Service recipient is seen in ER and a DI service is performed subsequent to the visit	Report a visit for the care received in ER. If performed, the DI service would be reported as part of the ER visit information if within the Linking Period established by the region (refer to Linking Period definition). **Note:** DI services should be reported only if performed. Determine for your facility if the majority of DI services ordered are performed or not. If completion of the service is unknown at the time of abstracting, apply the majority rule.
3. Service recipient is seen in a physician's office and asked to go to the hospital to have a DI service performed. After the service, the service recipient is seen in ER because of the findings	Report one visit, which includes the CCI code for the DI service as well as the information for the care received in ER.
4. Service recipient is seen in ER and a DI service is performed subsequent to the visit. After the DI service, the service recipient is again seen in ER because of the findings	Report one visit for the care initially received in ER. If possible, link the DI service to the first ER visit as it was requested at that time and is a result of that visit. Report another visit for the second time the service recipient is seen in ER.
5. Service recipient is an inpatient and has a DI service ordered which is performed later as a Discrete DI service recipient	Report a visit when the DI service is performed using the standard ambulatory care minimum data set. Report Mode of Service category "9" – Discrete DI.

Example	Reporting
6. Service recipient is seen in a physician's office and asked to go to the hospital to have a DI service performed	Report a visit when the DI service is performed using the standard ambulatory care minimum data set. Report Mode of Service category "9" – Discrete DI.
7. Service recipient is seen in Hospital A and referred to Hospital B for a DI service	At Hospital A, report an ambulatory care visit. **Note:** Reporting the code for the DI service is not required if the service recipient does not return to Hospital A. At Hospital B, report a visit when the service is performed using the standard ambulatory care minimum data set. Report Mode of Service category "9" – Discrete DI.
8. Service recipient is a patient in a long term care facility and is sent to a hospital's Diagnostic Imaging Department for a DI service	Report a visit when the DI service is performed using the standard ambulatory care minimum data set. Report Mode of Service category "9" – Discrete DI. **Note:** Reporting is the same regardless if the long term care facility is attached or is not attached to the hospital where the DI service is performed.

SECTION V. SERVICE RECIPIENT TRANSFERS - DISPOSITION REPORTING SCENARIOS

Please refer to Volume II: ACCS Data Manual, Page 44 for a description of the Disposition categories.

This document was originally reviewed at the Health Records Advisory Committee January 23, 1998. For clarification, #1 of the original document has been divided into 1a. and 1b.

1a. A service recipient is seen in Hospital A emergency department, transferred to Hospital B where an ACCS intervention is performed, transferred back to Hospital A emergency department, and discharged home. It <u>was not</u> known at the time of transfer to Hospital B that the service recipient would be transferred back to Hospital A emergency department.

Report the disposition category of 6 for the emergency visit prior to the ACCS intervention being performed, the disposition category of 6 for the ACCS intervention visit, and the disposition category of 1 for the emergency visit subsequent to the ACCS intervention being performed at Hospital B.

1b. A service recipient is seen in Hospital A emergency department, transferred to Hospital B where an ACCS intervention is performed, transferred back to Hospital A emergency department, and discharged home. It <u>was</u> known at the time of transfer to Hospital B that the service recipient would be transferred back to Hospital A emergency department.

Report the disposition category of 1 for the emergency visit which would include the portions before and after the service recipient was transferred to Hospital B. Report the disposition category of 6 for the ACCS intervention visit at Hospital B.

2. A service recipient is seen in Hospital A emergency department, transferred to Hospital B where an ACCS intervention is performed, and then admitted to the CCU in Hospital B.

Report the disposition category of 6 for the emergency visit and the disposition category of 4 for the ACCS intervention visit.

3. A service recipient is seen in Hospital A emergency department, transferred to the Day Surgery area of the same hospital where an ACCS intervention is performed, and then transferred back to the emergency department in Hospital A.

Report the disposition category of 1 for both the emergency and the Day Surgery visits. Disposition category of 5 is not intended to be used for service recipient transfers between ambulatory care areas of the same acute care hospital.

4. A service recipient is seen in Hospital A emergency department, transferred to the Day Surgery area of the same hospital where an ACCS intervention is performed, and then transferred to Hospital B and becomes an inpatient on the medicine floor.

Report the disposition category of 1 for the emergency visit and the disposition category of 6 for the Day Surgery visit.

5. An inpatient from Hospital A is transferred to Hospital B where an ACCS intervention is performed, and then transferred back to the inpatient ward of Hospital A.

Report the disposition category of 6 for the ACCS intervention visit.

6. A service recipient is seen in Hospital A emergency department and plans are made for inpatient admission. Prior to inpatient status being obtained, the service recipient is transferred to Hospital B where an ACCS intervention is performed. The service recipient then returns to Hospital A and is directly admitted to an inpatient medical unit.

Report the disposition category of 5 for the emergency visit at Hospital A as the intended final status for the service recipient is an inpatient within the facility. Report the disposition category of 6 for the ACCS intervention visit at Hospital B.

Tab:

Summary of Changes Effective April 1, 2008

Summary of Reporting Changes Effective April 1, 2008

Page	Section/ Data Element	Change
25 - 47	Coding Standards – Diagnosis Coding, Intervention Coding and Standards for Assigning Z codes for Ambulatory Care	Updated based upon CIHIs 2008-2009 Coding Standards.
82	Responsibility for Payment	Provided clarification to the description of code “02”.
83	Postal Code	Added a note to clarify postal code reporting for residents of Canada.
87	Admit via Ambulance	Added an ambulance type of "N" for "No ambulance”.
96	Anaesthetic Type	Clarified reporting of anaesthetic type which is mandatory for day surgery and emergency department visits if an intervention is performed.
115	Site Code	Introduced a new reporting requirement for ambulatory care services provided at a mobile unit.
Section 3	Psychology	Removed the term “rehabilitation” from title “PSYCHOLOGY (REHABILITATION)” and added a note to indicate that psychology codes and Alberta-developed attributes are designated for services provided by non-mental health programs.
Section 6	MIS Functional Centre Codes	Added a new MIS code of 71 5 14 - Community Advanced Ambulatory Care Centre.

Tab:

Data Elements

Mandatory Data Elements

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

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

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

1. Institution Number

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

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

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

Mandatory Data Elements

2. Submission Period

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

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

Valid values are:

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

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

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

3. Submission Number

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

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

Example : Record number 2
00000000000000000000000000000000002

Mandatory Data Elements

4. Submission Type

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

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

A Add record
C Change record
D Delete record

5. Unique Lifetime Identifier (ULI)

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

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

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

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

ULIs are mandatory to report for all ambulatory care visits. In cases where available patient information does not facilitate looking up a ULI in Person Directory or issuing a ULI (e.g. stillbirths, visits reported with Disposition 9), nine zeros (000000000) must be reported as the ULI.

6. Personal Health Number

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

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

The available entries include:

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

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

Mandatory Data Elements

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

- **9** = Stillbirth

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

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

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

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

Mandatory Data Elements

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

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

7. Responsibility For Payment

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

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

Valid values are:

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

8. Postal Code

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

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

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

NOTE: If the service recipient does not have a postal code assigned to his/her residence and receives their mail via a Canada Post Office outlet, record the postal code assigned to the Canada Post office. If the service recipient has both a place of residence postal code and a Canada Post Office postal code, report the postal code associated with the service recipient's place of residence.

Two digit postal code valid values are:

Code	Location	Code	Location
AB	Alberta	NH	New Hampshire
AK	Alaska	NJ	New Jersey
AL	Alabama	NL	Newfoundland and Labrador
AR	Arkansas	NM	New Mexico
AZ	Arizona	NS	Nova Scotia
BC	British Columbia	NT	Northwest Territories
CA	California	NU	Nunavut
CO	Colorado	NV	Nevada
CT	Connecticut	NY	New York
DC	District of Columbia	OC	Other Country
DE	Delaware	OH	Ohio
FL	Florida	OK	Oklahoma
GA	Georgia	ON	Ontario
HI	Hawaii	OR	Oregon
IA	Iowa	PA	Pennsylvania
ID	Idaho	PE	P.E.I.
IL	Illinois	QC	Quebec
IN	Indiana	RI	Rhode Island
KS	Kansas	SC	South Carolina
KY	Kentucky	SD	South Dakota
LA	Louisiana	SK	Saskatchewan
MA	Massachusetts	TN	Tennessee
MB	Manitoba	TX	Texas

Mandatory Data Elements

Code	Location	Code	Location
MD	Maryland	US	USA, state not known
ME	Maine	UT	Utah
MI	Michigan	VA	Virginia
MN	Minnesota	VT	Vermont
MO	Missouri	WA	Washington
MS	Mississippi	WI	Wisconsin
MT	Montana	WV	West Virginia
NB	New Brunswick	WY	Wyoming
NC	North Carolina	XX	Transient/Homeless
ND	North Dakota	YT	Yukon
NE	Nebraska		

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

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

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

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

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

9. Birth Date

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

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

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

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

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

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

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

10. Gender

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

The valid values for gender are:

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

11. Institution From

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

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

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

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

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

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

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

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

Mandatory Data Elements

12. Admit Via Ambulance

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

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

Valid values are:

Code	Description
A	Air ambulance
G	Ground ambulance
C	Combination of air and ground ambulance
N	Service recipient did not arrive by ambulance

13. Institution To

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

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

Institution To field is left blank when:

- a service recipient is transferred to other area of the reporting facility
- no transfer to another institution occurs

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

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

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

Mandatory Data Elements

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

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

14. Service Visit Date

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

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

Example (i): The service recipient was registered in the Emergency Department at 2200 hours on June 30, 2008 and was discharged at 0100 hours, July 1, 2008.
Visit date is 20080630

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

15. Doctor Number

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

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

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

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

Mandatory Data Elements

Example (i): Dr. Jones repaired Mr. Doe's hernia in Day/Night care. He is the physician responsible for Mr. Doe's care. His Doctor number is 3456789.
Enter 3456789_ _ _ _ _ _ _

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

16. Provider Type

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

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

NOTE: Provider type is mandatory to report for:

- Mental health visits.
- Emergency department and day surgery visits. At minimum it is mandatory to report the main service provider. Other providers may also be reported for emergency department and day surgery visits if desired.
- Videoconference visits when professional services paid for by the health region are provided.

Provider type is optional to report for other visits. Provider type may **not** be reported for videoconference visits if professional services paid for by the region are not provided.

Reporting standards for provider type are:

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

Mandatory Data Elements

Valid primary and secondary provider types are provided in Table 1 (sorted by Provider Type Description) and Table 2 (sorted by Code):

Table 1

Code	Provider Type Description	Code	Provider Type Description
03141	Audiologist	09999*	Other
09988*	Audiology Aide/Assistant	04154	Pastoral Care
03235	Audiology Technician	03131	Pharmacist
03217	Cardiology Technician	03142	Physical Therapist
06473	Child Care Assistant	03112	***Physician***
04164	Child Care Program Planning Officer	06631	Physiotherapy Aide/Assistant
04212	Child Care Worker	03123	Podiatrist
04165	Child Health Care Program Planning Officer	09977*	Polysomnographic Technologist
09971*	Child Life Specialist	09982*	Prosthetic Technician
03122	Chiropractor	09983*	Prosthetist
03223	Dental Technician	09990*	***Psychiatrist***
03113	Dentist	04151	***Psychologist***
09993*	Dialysis Assistant	09976*	***Psychology Assistant***
09994*	Dialysis Technician	04169	***Psychometrist***
06631	Dietary Aide	03215	Radiation Therapist/Radiological Technician
03219	Dietary Technologist	03111	Radiologist
04214	Early Childhood Development Therapist	09992*	***Recreational Aide/Assistant***
03218	EEG Technician	03144	***Recreational Therapist***
03234	Emergency Medical Technician	03132	Registered Dietitian
09995*	EMG Technician	03152	***Registered Nurse***
09996*	ENG Technician	09989*	***Registered Psychiatric Nurse***
09973*	Genetics Counsellor	09979*	Rehabiliation Engineer Aide/Technician
09974*	Independent Living Support Worker	09972*	Rehabilitation Practitioner
09985*	Kenesiologist	09991*	Resident
03413	Licensed Practical Nurse	09987*	Respiratory Aide/Assistant
09997*	Medical Student	03214	Respiratory Technician
04212	***Mental Health Therapist***	03214	Respiratory Therapist
03232	Midwife	04142	School Teacher
09978*	Nursing Attendant	09980*	Seating Technician
09984*	Nursing Practitioner	09975*	***Social Work Assistant***
03143	***Occupational Therapist***	04152	***Social Worker***
06631	***Occupational Therapy Aide/Assistant***	03216	Sonographer
05221	Ophthalmic Photographer	09986*	Speech-Language Aide/Assistant
03235	Ophthalmic Technician	03141	Speech-Language Pathologist
03414	Orthopaedic Technician	09998*	Student (other than medical)
09981*	Orthotic Technician	99999*	No Clinical Provider
03219	Orthotist		

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

Mandatory Data Elements

Table 2

Code	Provider Type Description	Code	Provider Type Description
03111	Radiologist	04214	Early Childhood Development Therapist
03112	Physician	05221	Ophthalmic Photographer
03113	Dentist	06473	Child Care Assistant
03122	Chiropractor	06631	Dietary Aide
03123	Podiatrist	06631	***Occupational Therapy Aide/Assistant***
03131	Pharmacist	06631	Physiotherapy Aide/Assistant
03132	Registered Dietitian	09971*	Child Life Specialist
03141	Audiologist	09972*	Rehabilitation Practitioner
03141	Speech-Language Pathologist	09973*	Genetics Counsellor
03142	Physical Therapist	09974*	Independent Living Support Worker
03143	***Occupational Therapist***	09975*	Social Work Assistant
03144	Recreational Therapist	09976*	Psychology Assistant
03152	Registered Nurse	09977*	Polysomnographic Technologist
03214	Respiratory Technician	09978*	Nursing Attendant
03214	Respiratory Therapist	09979*	Rehabiliation Engineer Aide/Technician
03215	Radiation Therapist/Radiological Technician	09980*	Seating Technician
03216	Sonographer	09981*	Orthotic Technician
03217	Cardiology Technician	09982*	Prosthetic Technician
03218	EEG Technician	09983*	Prosthetist
03219	Dietary Technologist	09984*	Nursing Practitioner
03219	Orthotist	09985*	Kenesiologist
03223	Dental Technician	09986*	Speech-Language Aide/Assistant
03232	Midwife	09987*	Respiratory Aide/Assistant
03234	Emergency Medical Technician	09988*	Audiology Aide/Assistant
03235	Audiology Technician	09989*	Registered Psychiatric Nurse
03235	Ophthalmic Technician	09990*	Psychiatrist
03413	Licensed Practical Nurse	09991*	Resident
03414	Orthopaedic Technician	09992*	Recreational Aide/Assistant
04142	School Teacher	09993*	Dialysis Assistant
04151	Psychologist	09994*	Dialysis Technician
04152	Social Worker	09995*	EMG Technician
04154	Pastoral Care	09996*	ENG Technician
04164	Child Care Program Planning Officer	09997*	Medical Student
04165	Child Health Care Program Planning Officer	09998*	Student (other than medical)
04169	Psychometrist	09999*	Other
04212	Child Care Worker	99999*	No Clinical Provider
04212	***Mental Health Therapist***		

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

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

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

17. MIS Primary Code

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

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

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

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

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

18. Mode of Service

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

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

Mandatory Data Elements

Valid values are:

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

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

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

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

19. Disposition

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

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

Valid values are:

Code	Description
1	Discharged - visit concluded.
2	Discharged from program or clinic - will not return for further care. (This refers only to the last visit of a service recipient discharged from a treatment program at which he/she has been seen for repeat services).
3	Left against medical advice. (Intended care not completed.)
4	Service recipient admitted as an inpatient to Critical Care Unit or OR in own facility.
5	Service recipient admitted to another area in own facility. (Note: area must be represented by the same last three digits of the institution number as the ambulatory care facility).
6	Service recipient transferred to another acute care facility. This includes transfers to rehab (level of care 4), psychiatric (level of care 5), oncology and pediatric facilities.
7	DAA – Service recipient expired in ambulatory care service.
8	DOA – Service recipient dead on arrival to ambulatory care service.
9	Left without being seen. (Not seen by a professional service provider).
0	No doctor available – service recipient asked to return later. Note: Disposition 0 should only be used for emergency department visits.

20. Diagnosis Prefix

(May report a maximum of 10)

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

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

Mandatory Data Elements

21. Main Ambulatory Care Diagnosis

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

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

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

22. Secondary Diagnoses

(May report a maximum of 9)

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

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

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

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

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

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

23. Anaesthetic Type

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

Anaesthetic type identifies the type of anaesthetic used for interventions.

NOTE: Anaesthetic type is mandatory to report for day surgery and emergency department visits if an intervention is performed.

Valid values are:

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

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

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

24. Main Intervention

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

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

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

25. Other Interventions

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

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

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

26. Intervention Attributes

(May report a maximum of 10 sets)
(Status: SF #436, 438, 440, 442, 444, 446, 448, 450, 452, 454, Mandatory as specified, Len=2, A, LJ)

(Location: SF #456, 458, 460, 462, 464, 466, 468, 470, 472, 474, Mandatory as specified, Len=2 A, LJ)

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

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

See Section 3 for attribute codes that are mandatory to report. Other attribute codes are optional to report at this time.

27. Out Of Hospital Indicator

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

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

Valid values are:

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

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

28. Triage Level

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

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

Valid values are:

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

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

The triage level is 3, urgent.

Mandatory Data Elements

Emergency Triage and Acuity Scale

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

Mandatory Data Elements

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

Mandatory Data Elements

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

Mandatory Data Elements

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

Optional Fields on File Layout

29. Number of Previous Term Deliveries for Therapeutic Abortion Cases

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

The number of previous full term deliveries (37+ completed weeks gestation). Valid values include 00-20 and 99 (not available).

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

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

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

The number of previous pre-term deliveries (20-36 completed weeks gestation). Valid values include 00-20 and 99 (not available).

Example: *Service recipient having a therapeutic abortion performed had no previous pre-term deliveries.*
Report 00.

31. Number of Previous Spontaneous Abortions for Therapeutic Abortion Cases

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

The number of previous spontaneous abortions that the service recipient has had. Valid values include 00-20 and 99 (not available).

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

Report 01.

32. Gestational Age for Therapeutic Abortion Cases

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

The gestational age, reported in weeks. Valid values include 01-25 and 99 (not available).

Optional Data Elements

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

Report 12

33. Number of Previous Therapeutic Abortions for Therapeutic Abortion Cases

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

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

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

Report 01.

34. Date of Last Menses for Therapeutic Abortion Cases

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

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

Example: Service recipient having a therapeutic abortion performed had an unknown gestational age. However, it was known that the service recipient's last menses was July 20, 2008.

Report 20080720.

Optional Data Elements

35. Triage Date

(SF #597. Optional, Len=8, N, N/A)

The calendar date, in YYYYMMDD format, when the service recipient was triaged in the emergency department. Triage date pertains only to service recipients seen in an Emergency Department (MIS 71310^^) or in a Community Urgent Care Centre (MIS 71513)**.**

Note: As of April 1, 2006 triage date is mandatory to report for urban hospitals.

Example (i): The service recipient was triaged in the emergency department on June 30, 2008.

Enter 20080630.

36. Triage Time

(SF #605. Optional, Len=4, N, N/A)

The time (in hours/minutes) when the service recipient was triaged in the emergency department. The hour is reported using the 24 hour clock. Triage time pertains only to service recipients seen in an Emergency Department (MIS 71310^^) or in a Community Urgent Care Centre (MIS 71513).

Note: As of April 1st, 2006 triage time is mandatory to report for urban hospitals.

Example (i): The service recipient was triaged in the emergency department at 1800 hours.

Enter 1800.

37. Registration Time

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

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

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

Enter 1145.

Optional Data Elements

38. Date of Physician Initial Assessment

(SF #609. Optional, Len=8, N, N/A)

The calendar date, in YYYYMMDD format, when the first physician initially assesses the service recipient. Date of Physician Initial Assessment pertains only to service recipients seen in an Emergency Department (MIS 71310^^) or in a Community Urgent Care Centre (MIS 71513) and is left blank if a physician does not see the service recipient.

Example (i): The service recipient was initially assessed by a physician in the emergency department on January 25, 2008.

Enter 20080125.

39. Time of Physician Initial Assessment

(SF #617. Optional, Len=4, N, N/A)

The time (in hours/minutes) when the first physician initially assesses the service recipient. The hour is recorded using the 24 hour clock. Time of Physician Initial Assessment pertains only to service recipients seen in an Emergency Department (MIS 71310^^) or in a Community Urgent Care Centre (MIS 71513) and is left blank if a physician does not see the service recipient.

Example (i): The service recipient was initially assessed by a physician at 0515 hours.

Enter 0515.

40. Date Visit Completed

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

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

Example (i): The service recipient is registered in day surgery on June 5, 2008 and following surgery, returns home the same day.

Enter 20080605

Example (ii): The service recipient is registered in day surgery on June 5, 2008 at 2000 hours and returns home at 0600 hours June 6, 2008.

Enter 20080606

Optional Data Elements

41. Disposition Time

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

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

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

Example : The service recipient was discharged at 1515 hours.

Enter 1515.

42. Residence Name

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

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

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

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

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

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

Non-resident of Alberta, but a resident of Canada, code the province or territory name only, right justified.
Example (iii): Regina, Saskatchewan = _ _ _ _ _SK

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

Optional Data Elements

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

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

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

Residence Name: Abbreviations

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

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

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

Optional Data Elements

The following residence locations must be abbreviated:

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

43. Doctor Type

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

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

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

Optional Data Elements

44. Doctor Service

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

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

DOCTOR SERVICE NUMBERS

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

Optional Data Elements

Specialty	Service Number
Urology	00039
Paediatric General Surgery	00040
Paediatric Cardiac Surgery	00041
Paediatric Neurosurgery	00042
Paediatric Orthopedic Surgery	00044
Paediatric Plastic Surgery	00045
Paediatric Thoracic Surgery	00046
Paediatric Vascular Surgery	00047
Paediatric Cardiothoracic Surgery	00048
Paediatric Urology	00049
Obstetrics & Gynaecology	00050
Gynecologic Reproductive Endocrinology & Infertility	00051
Urogynaecology	00053
Maternal-Fetal Medicine	00054
Critical Care Medicine	00055
Clinical Pharamacology	00056
Anaesthesia	00057
Paediatric Anesthesia	00058
Colorectal Surgery	00059
Otolaryngology	00060
Paediatric Otolaryngology	00061
Ophthalmology	00062
Paediatric Ophthalmology	00063
Psychiatry	00064
Paediatric Psychiatry	00065
Haematology	00066
Paediatric Haematology	00067
Physical Medicine & Rehabilitation.	00070
Geriatric Medicine	00072
General Surgical Oncology	00073
Medical Oncology	00074
Radiation Oncology	00075
Gynaecological Oncology	00076
General Pathology	00077
Medical Microbiology	00078
Diagnostic Radiology	00080
Medical Genetics	00082
Anatomical Pathology	00083
Haematological Pathology	00085
Neuropathology	00086
Nuclear Medicine	00089
Medical Biochemistry	00090

Optional Data Elements

Specialty	Service Number
Paediatric Radiology	00092
Neuroradiology	00093
Infectious Disease Specialist	00096
Neonatal-Perinatal Medicine	00097
Dentist	01001
Dental Surgeon	01002
Oral Surgeon	01003
Paediatric Oral Surgeon	01012
Paediatric Dentist	01013
Podiatrist	02001
Midwife	11004

45. Chart Number

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

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

Example (i): Chart Number 234567891098

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

46. Referral Source

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

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

Valid values are:

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

Optional Data Elements

08	Other individual/agency (e.g. private organizations)
09	Significant other
10	Educational institution
11	Self
12	Unknown

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

The Referral Source is 00.

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

The Referral Source is 06.

47. Referred-To Agency

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

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

Valid values are:

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

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

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

Optional Data Elements

48. Stakeholder Type

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

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

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

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

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

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

The Stakeholder Type is 1.

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

The Stakeholder Type is 2.

49. Coder Number

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

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

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

The Coder Number is 03.

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

The Coder Number is 10.

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

50. Record Type

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

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

51. Fiscal Year

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

Represented by the year the fiscal year concludes in. For example, the fiscal year April 1, 2008 to March 31, 2009 is represented by the year 2009.

52. Site Code

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

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

NOTE: Value of "99" is mandatory to report for all ambulatory care services provided at a mobile unit.

53. Service Event Number

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

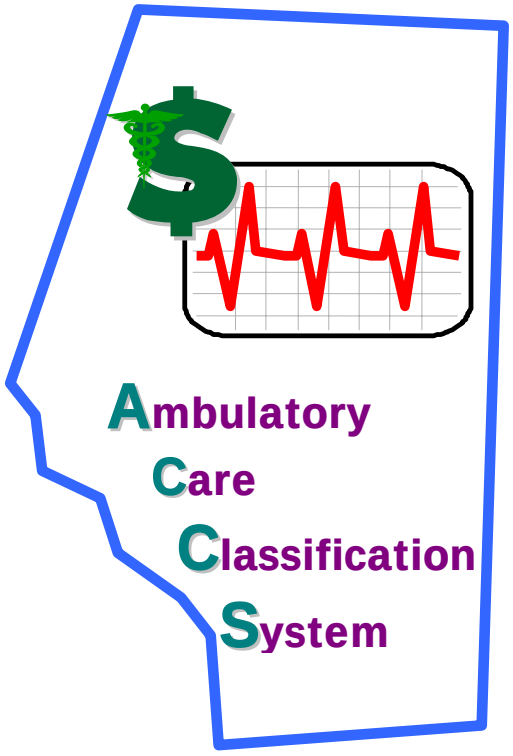
The service event number is used for internal facility identification of a service event.

54. Encounter Number

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

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

Alberta

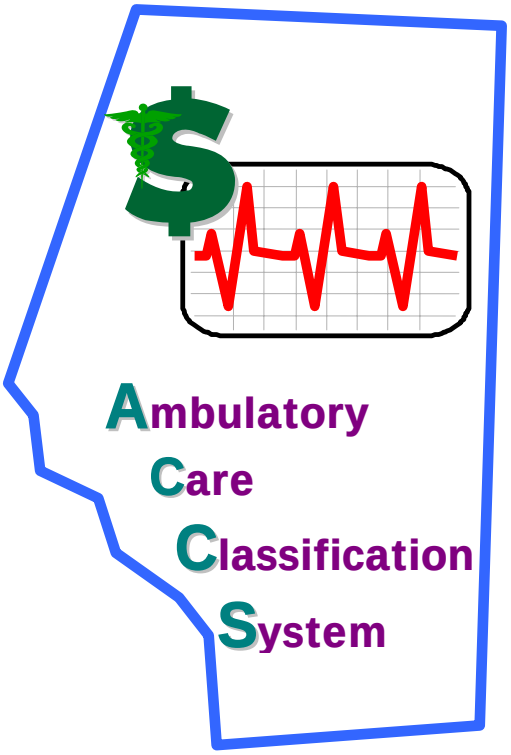


1. List of Major Ambulatory Categories

Effective April 2008

In this section of the documentation, a list of Major Ambulatory Categories (MAC) is presented. MAC represent a higher level grouping of ACCS cells.

The MAC list is available as a downloadable self-extracting file in Excel and Access format. To download the list, go to http://www.health.gov.ab.ca/.
Under News/Media/Resources select Publications. Next go to Ambulatory Care and Alberta Ambulatory Care Reporting Manual 2008.



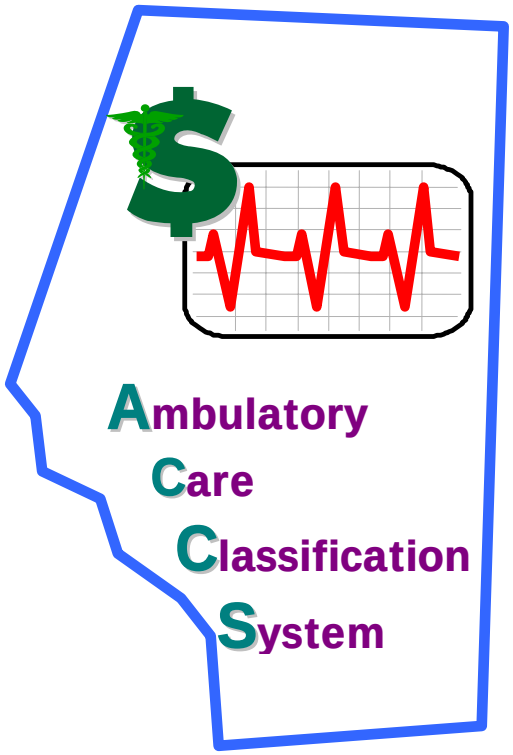
2. List of ACCS Grouper Cells

Effective April 2008

In this section of the documentation, a list of Ambulatory Care Classification System (ACCS) grouper cells is presented. The ACCS grouper classifies ambulatory care records into clinically and resource homogenous cells.

The ACCS grouper cell list is available as a downloadable self-extracting file in Excel and Access format. To download the list, go to http://www.health.gov.ab.ca/. Under News/Media/Resources select Publications. Next go to Ambulatory Care and Alberta Ambulatory Care Reporting Manual 2008.

Alberta



3. Alberta Developed Attribute Codes

Effective April 2008

Reporting Methodology

In this section of the documentation, a list of interventions with Alberta-developed attribute codes is presented.

Each CCI intervention code has a potential of having three “attributes.” The function of an attribute is to provide extra detail about the intervention (or the episode for the intervention). The three attributes include:

- S = Status
- L = Location
- E = Extent.

Each attribute may include 1 or 2 characters; alpha or numeric.

Because unique codes do not exist for each service provided (e.g. physical therapy assessment of low, medium, and high), attribute codes have been developed to acquire uniqueness. For example, the CCI code for physical therapy assessment is 2ZZ02ZU. An extent code of 1 (low 1-20 minutes) 2 (medium 21-45 minutes), or 3 (high, 46+ minutes) needs to be assigned to each CCI code as appropriate. In addition, because the code 2ZZ02ZU may be reported for a non-physical therapy visit, a location attribute of PT (physical therapy) will also be assigned for each intervention reported by a physical therapist. This reporting is required to ensure visits get grouped correctly.

In summary as an example, a CCI code, along with a location code of PT and an extent code of 1,2 or 3 would be assigned for each physical therapy service provided. However, not all of the previous six-digit intervention codes require the assignment of attribute codes as you will see in the following documentation.

Please note that each “developed” attribute code is in addition to CIHI’s valid attribute codes. Therefore, the same attribute code does not have two definitions.

The list of interventions with Alberta-developed attribute codes is also available as a downloadable self-extracting file in Excel and Access format. To download the list, go to http://www.health.gov.ab.ca/.
Under News/Media/Resources select Publications. Next go to Ambulatory Care and Alberta Ambulatory Care Reporting Manual 2008.

Alberta Developed Attribute Codes

SLEEP STUDIES

INTERVENTION	INTERVENTION DESCRIPTION	INTERVENTION CODE
Other Sleep Study	Ventilation, respiratory system using per orifice approach and positive pressure mechanical ventilator	1GZ31CAND S=SL
Extensive Sleep Study	Other study, brain approach/technique NEC	2AN59ZZ S=SS
Other Sleep Study	Other study, brain approach/technique NEC	2AN59ZZ S=SL

DIAGNOSTIC IMAGING

INTERVENTION	INTERVENTION DESCRIPTION	INTERVENTION CODE
OBS Nuclear Imaging	Other antepartum diagnostic imaging examination using other imaging techniques	5AB05GZ S=NI
OBS CT Scan	Other antepartum diagnostic imaging examination using other imaging techniques	5AB05GZ S=CT
OBS MRI	Other antepartum diagnostic imaging examination using other imaging techniques	5AB05GZ S=MR
OBS Chest Xray	Xray, thoracic cavity, antepartum diagnostic imaging	5AB05GZ S=CX
Other Xray	Xray, antepartum diagnostic imaging	5AB05GZ S=XR

NEPHROLOGICAL - DIALYSIS INTERVENTIONS

INTERVENTION	DEFINITION	INTERVENTION CODE
Hemodialysis	As per CCI	1PZ21HQBR
Home Hemodialysis Teaching	Teaching services provided to patients learning to perform hemodialysis at home	7SC59QD S=HT
Self Care Hemodialysis	Patient performs hemodialysis and requires only minimal nursing assistance	7SC59QD S=HS
Peritoneal Dialysis	As per CCI	1PZ21HPD4
Home Peritoneal Dialysis Teaching	Teaching services provided to patients learning to perform peritoneal dialysis at home	7SC59QD S=PT

MENTAL HEALTH INTERVENTIONS

INTERVENTION	DEFINITION	INTERVENTION/ ATTRIBUTE CODE
Assessment-Referral	Screening to determine initial type of services required. (Includes triage calls).	2AZ02ZZ S=R L=MH
Assessment-Intake	In-depth assessment of client requirements for services (may include, for example, mental status, history, etc.)	2AZ02ZZ S=N L=MH
Assessment-Collateral	Contact with a collateral person for the purpose of obtaining assessment information.	2AZ02ZZ S=C L=MH
Legal Assessment Half Day (≤ 4 hours)	Court ordered assessment.	2AZ02AE E=1 L=MH
Full Day (> 4 hours)	Court ordered assessment.	2AZ02AE E=2 L=MH
Assessment-Specialized	Specialized assessment such as vocational training, ECT work-up, other discipline specific assessments, community based crisis assessments.	2AZ02ZZ S=Z L=MH

NOTE: Location attribute code of MH (mental health) required for all mental health interventions.

MENTAL HEALTH INTERVENTIONS

INTERVENTION	DEFINITION	INTERVENTION CODE
Reassessment	An assessment completed subsequent to an initial assessment to determine the mental health status of a service recipient and ongoing services required.	2AZ02ZZ S=P L=MH
Crisis/Intervention Calls Telephone Crisis Call	Telephone crisis calls for the purposes of addressing immediate personal/familial crisis.	6AA10CT S=T L=MH
Mobile Crisis Intervention Call	An unscheduled visit to a client's location to address an immediate mental health crisis.	6AA10CT S=M L=MH
Individual Therapy	Therapy provided by any service provider type-therapeutic focus is not the couple or family unit.	6AA30ZZZZ S=IN L=MH
Couple Therapy	Therapy which has as its primary focus a relationship with a significant other but not on the remainder of the family. Significant other may or may not be present. A contact form is completed only for the program client.	6DA30DCZZ L=MH
Family Therapy	Therapy which has as its primary focus the familial system. A contact form is completed only for the program client. Family may or may not be present.	6DA30DFZZ L=MH
Group Therapy	Contacts spent within a therapeutic group context. A group contact form will be completed.	6AA30ZZZZ S=GR L=MH
ECT	Contact to prepare for or administer ECT treatment.	1AN09JADV L=MH
Medication Administration	Administration of an oral, topical or injected medication.	1ZZ35YAT2 L=MH
Medication Assessment	Review of medications.	2ZZ02ZT L=MH
Patient Specific/ Consultations Case Supervision	Consults with other professionals or collaterals for the purpose of case management and discharge planning. (For reporting purposes, each service professional reports ONLY on their own patients).	7SF12ZZ L=MH
Patient Specific Hearings	Testifying in legal hearing (eg., Court Appearance, Review Panels, Board of Review, WCB).	7SJ34PZ L=MH
Patient Specific Professional Reports and Applications	Occasional documentation required for legal, financial or clinical purposes. EG., writing reports and applications such as AISH applications, WCB reports, court reports. (Excludes routine documentation and charting.)	7SJ30LZ L=MH

MENTAL HEALTH INTERVENTIONS

INTERVENTION	DEFINITION	INTERVENTION CODE
Patient Specific Critical Incident Documentation	All formal reports required as a result of managing a specific critical incident.	7SJ30LD L=MH
Diagnostic Testing/Scoring Testing Type 1 (≤ 2 hours)	Face to face contact for the purpose of administration of any professional testing or neuropsychological assessment intervention. Any reporting using this category must be accompanied by a write-up in the form of an assessment report.	2AZ08ZZ E=1 L=MH
Testing Type 2 Half Day (> 2 hours and ≤ 4 hours)		2AZ08ZZ E=2 L=MH
Testing Type 3 Full Day (> 4 hours)		2AZ08ZZ E=3 L=MH
Therapeutic Milieu Programs Half Day (≤ 4 hours)	A non-structured or semi-structured activity for the purposes of observation and/or therapy including informal teaching and social interaction.	6AA30ZZZZ E=1 L=MH
Full Day (> 4 hours)		6AA30ZZZZ E=2 L=MH
Mental Health Education 0-120 minutes (2 hours)	Education of individuals or groups with the direct purpose of improving mental health status either now or in future (i.e., includes primary and secondary prevention, as well as promotion).	6AA10ZZ E=11 L=MH
121-240 minutes (4 hours)		6AA10ZZ E=12 L=MH
241-360 minutes (6 hours)		6AA10ZZ E=13 L=MH
361-480 minutes (8 hours)		6AA10ZZ E=14 L=MH

- NB: Routine documentation is included with each intervention.

ASSOCIATED MENTAL HEALTH DEFINITIONS

COLLATERAL
A person who is associated with a mental health client.

CONTACT
A contact is the occurrence of a face to face or technologically mediated (ie., telephone, teleconference, videoconference) contact with a mental health client/patient in which the **MAJOR** intent is to provide psychological or psychiatric treatment.

REHABILITATION INTERVENTIONS
OCCUPATIONAL THERAPY

INTERVENTION AND DEFINITION	INTERVENTION CODE		
	LOW (0-20 MIN) Extent=1	MED (21-45 MIN) Extent=2	HIGH (46+ MIN) Extent=3
ASSESSMENT Activities for the sole purposes of evaluating the need for the service, the nature of the problem, the identification of the disorder or abnormality and the extent of services required. Is a formal, comprehensive process which generally uses specific assessment tools or methods to assess physical, psycho-social, cognitive abilities, medical requirements, environment and formal and informal supports. Includes preparation, collection of information, analysis of the assessment information, formulation of a working diagnosis, development of the care/treatment plan and documentation of assessment findings from the patient, family, employer, teacher, written records including medical charts and other sources. Excludes the ongoing evaluation associated with a specific intervention.	2ZZ02ZV L=OT	2ZZ02ZV L=OT	2ZZ02ZV L=OT
THERAPEUTIC INTERVENTION Activities carried out with a patient/significant other(s) that are aimed at improving/maintaining health status, or minimizing the impact of deterioration on the quality of life. Includes the preparation for treatment of a patient(s), the provision of specific techniques and procedures to a patient(s), support activities, monitoring of the patient's progress to evaluate the result of a specific intervention and the need to continue and/or modify treatment, and the related clinical documentation.	6VA30ZZ L=OT	6VA30ZZ L=OT	6VA30ZZ L=OT
CONSULTATION/COLLABORATION **(Must be linked to assessment and/or therapeutic intervention CCI code)** Formal or informal contact with personnel of the facility, community or other agencies for discussion regarding specific patients and/or significant others, in order to obtain, provide or exchange information relative to the patient's care. Includes any regularly scheduled/attended meetings of professionals to coordinate team efforts in services to patients, and the related clinical documentation	7SF15ZZ L=OT	7SF15ZZ L=OT	7SF15ZZ L=OT

NOTE: Location attribute code of OT (Occupational Therapy) required for all Occupational Therapy intervention codes.

PHYSICAL THERAPY

INTERVENTION AND DEFINITION	INTERVENTION CODE		
	LOW (0-20 MIN) Extent=1	MED (21-45 MIN) Extent=2	HIGH (46+ MIN) Extent=3
ASSESSMENT Activities for the sole purposes of evaluating the need for the service, the nature of the problem, the identification of the disorder or abnormality and the extent of services required. Is a formal, comprehensive process which generally uses specific assessment tools or methods to assess physical, psycho-social, cognitive abilities, medical requirements, environment and formal and informal supports. Includes preparation, collection of information, analysis of the assessment information, formulation of a working diagnosis, development of the care/treatment plan and documentation of assessment findings from the patient, family, employer, teacher, written records including medical charts and other sources. Excludes the ongoing evaluation associated with a specific intervention.	2ZZ02ZU L=PT	2ZZ02ZU L=PT	2ZZ02ZU L=PT
THERAPEUTIC INTERVENTION Activities carried out with a patient/significant other(s) that are aimed at improving/maintaining health status, or minimizing the impact of deterioration on the quality of life. Includes the preparation for treatment of a patient(s), the provision of specific techniques and procedures to a patient(s), support activities, monitoring of the patient's progress to evaluate the result of a specific intervention and the need to continue and/or modify treatment, and the related clinical documentation.	1ZX02YD L=PT	1ZX02YD L=PT	1ZX02YD L=PT
CONSULTATION/COLLABORATION **(Must be linked to assessment and/or therapeutic intervention CCI code)** Formal or informal contact with personnel of the facility, community or other agencies for discussion regarding specific patients and/or significant others, in order to obtain, provide or exchange information relative to the patient's care. Includes any regularly scheduled/attended meetings of professionals to coordinate team efforts in services to patients, and the related clinical documentation	7SF15ZZ L=PT	7SF15ZZ L=PT	7SF15ZZ L=PT

NOTE: Location attribute code of PT (Physical Therapy) required for all Physical Therapy intervention codes.

RECREATIONAL THERAPY

INTERVENTION AND DEFINITION	INTERVENTION CODE		
	LOW (0-20 MIN) Extent=1	MED (21-45 MIN) Extent=2	HIGH (46+ MIN) Extent=3
ASSESSMENT Activities for the sole purposes of evaluating the need for the service, the nature of the problem, the identification of the disorder or abnormality and the extent of services required. Is a formal, comprehensive process which generally uses specific assessment tools or methods to assess physical, psycho-social, cognitive abilities, medical requirements, environment and formal and informal supports. Includes preparation, collection of information, analysis of the assessment information, formulation of a working diagnosis, development of the care/treatment plan and documentation of assessment findings from the patient, family, employer, teacher, written records including medical charts and other sources. Excludes the ongoing evaluation associated with a specific intervention.	2ZZ02ZZ L=RE	2ZZ02ZZ L=RE	2ZZ02ZZ L=RE
THERAPEUTIC INTERVENTION Activities carried out with a patient/significant other(s) that are aimed at improving/maintaining health status, or minimizing the impact of deterioration on the quality of life. Includes the preparation for treatment of a patient(s), the provision of specific techniques and procedures to a patient(s), support activities, monitoring of the patient's progress to evaluate the result of a specific intervention and the need to continue and/or modify treatment, and the related clinical documentation.	6AA30MASA L=RE	6AA30MASA L=RE	6AA30MASA L=RE
CONSULTATION/COLLABORATION **(Must be linked to assessment and/or therapeutic intervention CCI code)** Formal or informal contact with personnel of the facility, community or other agencies for discussion regarding specific patients and/or significant others, in order to obtain, provide or exchange information relative to the patient's care. Includes any regularly scheduled/attended meetings of professionals to coordinate team efforts in services to patients, and the related clinical documentation	7SF15ZZ L=RE	7SF15ZZ L=RE	7SF15ZZ L=RE

NOTE: Location attribute code of RE (Recreational Therapy) required for all Recreational Therapy intervention codes.

SPEECH LANGUAGE PATHOLOGY

INTERVENTION AND DEFINITION	INTERVENTION CODE		
	LOW (0-20 MIN) Extent=1	MED (21-45 MIN) Extent=2	HIGH (46+ MIN) Extent=3
ASSESSMENT Activities for the sole purposes of evaluating the need for the service, the nature of the problem, the identification of the disorder or abnormality and the extent of services required. Is a formal, comprehensive process which generally uses specific assessment tools or methods to assess physical, psycho-social, cognitive abilities, medical requirements, environment and formal and informal supports. Includes preparation, collection of information, analysis of the assessment information, formulation of a working diagnosis, development of the care/treatment plan and documentation of assessment findings from the patient, family, employer, teacher, written records including medical charts and other sources. Excludes the ongoing evaluation associated with a specific intervention.	2GE02FF (speech) L=SL OR 2GE02FG (language) L=SL	2GE02FF (speech) L=SL OR 2GE02FG (language) L=SL	2GE02FF (speech) L=SL OR 2GE02FG (language) L=SL
THERAPEUTIC INTERVENTION Activities carried out with a patient/significant other(s) that are aimed at improving/maintaining health status, or minimizing the impact of deterioration on the quality of life. Includes the preparation for treatment of a patient(s), the provision of specific techniques and procedures to a patient(s), support activities, monitoring of the patient's progress to evaluate the result of a specific intervention and the need to continue and/or modify treatment, and the related clinical documentation.	6RA50RBSZ L=SL	6RA50RBSZ L=SL	6RA50RBSZ L=SL
CONSULTATION/COLLABORATION **(Must be linked to assessment and/or therapeutic intervention CCI code)** Formal or informal contact with personnel of the facility, community or other agencies for discussion regarding specific patients and/or significant others, in order to obtain, provide or exchange information relative to the patient's care. Includes any regularly scheduled/attended meetings of professionals to coordinate team efforts in services to patients, and the related clinical documentation	7SF15ZZ L=SL	7SF15ZZ L=SL	7SF15ZZ L=SL

NOTE: Location attribute code of SL (Speech Language) required for all Speech Language Pathology intervention codes.

REHABILITATION INTERVENTIONS
AUDIOLOGY

INTERVENTION AND DEFINITION	INTERVENTION CODE		
	LOW (0-20 MIN) Extent=1	MED (21-45 MIN) Extent=2	HIGH (46+ MIN) Extent=3
ASSESSMENT Activities for the sole purposes of evaluating the need for the service, the nature of the problem, the identification of the disorder or abnormality and the extent of services required. Is a formal, comprehensive process which generally uses specific assessment tools or methods to assess physical, psycho-social, cognitive abilities, medical requirements, environment and formal and informal supports. Includes preparation, collection of information, analysis of the assessment information, formulation of a working diagnosis, development of the care/treatment plan and documentation of assessment findings from the patient, family, employer, teacher, written records including medical charts and other sources. Excludes the ongoing evaluation associated with a specific intervention.	2DZ02ZZ L=AU	2DZ02ZZ L=AU	2DZ02ZZ L=AU
THERAPEUTIC INTERVENTION Activities carried out with a patient/significant other(s) that are aimed at improving/maintaining health status, or minimizing the impact of deterioration on the quality of life. Includes the preparation for treatment of a patient(s), the provision of specific techniques and procedures to a patient(s), support activities, monitoring of the patient's progress to evaluate the result of a specific intervention and the need to continue and/or modify treatment, and the related clinical documentation.	6PA10ZZ L=AU	6PA10ZZ L=AU	6PA10ZZ L=AU
CONSULTATION/COLLABORATION **(Must be linked to assessment and/or therapeutic intervention CCI code)** Formal or informal contact with personnel of the facility, community or other agencies for discussion regarding specific patients and/or significant others, in order to obtain, provide or exchange information relative to the patient's care. Includes any regularly scheduled/attended meetings of professionals to coordinate team efforts in services to patients, and the related clinical documentation	7SF15ZZ L=AU	7SF15ZZ L=AU	7SF15ZZ L=AU

NOTE: Location attribute code of AU (Audiology) is required for all Audiology intervention codes.

AUDIOLOGY

INTERVENTION AND DEFINITION	INTERVENTION CODE		
	LOW (0-60 MIN) Extent=4	MED (61-120 MIN) Extent=5	HIGH (120+ MIN) Extent=6
COCHLEAR Treatment for Implant	2DM24ZZ L=AU	2DM24ZZ L=AU	2DM24ZZ L=AU

NOTE: Location attribute code of AU (Audiology) is required for all Audiology intervention codes.

RESPIRATORY THERAPY

INTERVENTION AND DEFINITION	INTERVENTION CODE		
	LOW (0-20 MIN) Extent=1	MED (21-45 MIN) Extent=2	HIGH (46+ MIN) Extent=3
ASSESSMENT Activities for the sole purposes of evaluating the need for the service, the nature of the problem, the identification of the disorder or abnormality and the extent of services required. Is a formal, comprehensive process which generally uses specific assessment tools or methods to assess physical, psycho-social, cognitive abilities, medical requirements, environment and formal and informal supports. Includes preparation, collection of information, analysis of the assessment information, formulation of a working diagnosis, development of the care/treatment plan and documentation of assessment findings from the patient, family, employer, teacher, written records including medical charts and other sources. Excludes the ongoing evaluation associated with a specific intervention.	2GZ29ZZ L=RT	2GZ29ZZ L=RT	2GZ29ZZ L=RT
THERAPEUTIC INTERVENTION Activities carried out with a patient/significant other(s) that are aimed at improving/maintaining health status, or minimizing the impact of deterioration on the quality of life. Includes the preparation for treatment of a patient(s), the provision of specific techniques and procedures to a patient(s), support activities, monitoring of the patient's progress to evaluate the result of a specific intervention and the need to continue and/or modify treatment, and the related clinical documentation.	1GZ12ZZ L=RT	1GZ12ZZ L=RT	1GZ12ZZ L=RT
CONSULTATION/COLLABORATION **(Must be linked to assessment and/or therapeutic intervention CCI code)** Formal or informal contact with personnel of the facility, community or other agencies for discussion regarding specific patients and/or significant others, in order to obtain, provide or exchange information relative to the patient's care. Includes any regularly scheduled/attended meetings of professionals to coordinate team efforts in services to patients, and the related clinical documentation	7SF15ZZ L=RT	7SF15ZZ L=RT	7SF15ZZ L=RT

NOTE: Location attribute code of RT (Respiratory Therapy) is required for all Respiratory Therapy intervention codes.

NON REHABILITATION INTERVENTIONS

CLINICAL NUTRITION

INTERVENTION AND DEFINITION	INTERVENTION CODE		
	LOW (0-20 MIN) Extent=1	MED (21-45 MIN) Extent=2	HIGH (46+ MIN) Extent=3
ASSESSMENT Activities for the sole purposes of evaluating the need for the service, the nature of the problem, the identification of the disorder or abnormality and the extent of services required. Is a formal, comprehensive process which generally uses specific assessment tools or methods to assess physical, psycho-social, cognitive abilities, medical requirements, environment and formal and informal supports. Includes preparation, collection of information, analysis of the assessment information, formulation of a working diagnosis, development of the care/treatment plan and documentation of assessment findings from the patient, family, employer, teacher, written records including medical charts and other sources. Excludes the ongoing evaluation associated with a specific intervention.	2ZZ02ZS L=CN	2ZZ02ZS L=CN	2ZZ02ZS L=CN
THERAPEUTIC INTERVENTION Activities carried out with a patient/significant other(s) that are aimed at improving/maintaining health status, or minimizing the impact of deterioration on the quality of life. Includes the preparation for treatment of a patient(s), the provision of specific techniques and procedures to a patient(s), support activities, monitoring of the patient's progress to evaluate the result of a specific intervention and the need to continue and/or modify treatment, and the related clinical documentation.	7SP59ZZ L=CN	7SP59ZZ L=CN	7SP59ZZ L=CN
CONSULTATION/COLLABORATION **(Must be linked to assessment and/or therapeutic intervention CCI code)** Formal or informal contact with personnel of the facility, community or other agencies for discussion regarding specific patients and/or significant others, in order to obtain, provide or exchange information relative to the patient's care. Includes any regularly scheduled/attended meetings of professionals to coordinate team efforts in services to patients, and the related clinical documentation	7SF15ZZ L=CN	7SF15ZZ L=CN	7SF15ZZ L=CN

NOTE: Location attribute code of CN (Clinical Nutrition) is required for all Clinical Nutrition intervention codes.

SOCIAL WORK

INTERVENTION AND DEFINITION	INTERVENTION CODE		
	LOW (0-60 MIN) Extent=4	MED (61-120 MIN) Extent=5	HIGH (120+ MIN) Extent=6
ASSESSMENT Activities for the sole purposes of evaluating the need for the service, the nature of the problem, the identification of the disorder or abnormality and the extent of services required. Is a formal, comprehensive process which generally uses specific assessment tools or methods to assess physical, psycho-social, cognitive abilities, medical requirements, environment and formal and informal supports. Includes preparation, collection of information, analysis of the assessment information, formulation of a working diagnosis, development of the care/treatment plan and documentation of assessment findings from the patient, family, employer, teacher, written records including medical charts and other sources. Excludes the ongoing evaluation associated with a specific intervention.	2ZZ02ZZ L=SW	2ZZ02ZZ L=SW	2ZZ02ZZ L=SW
THERAPEUTIC INTERVENTION Activities carried out with a patient/significant other(s) that are aimed at improving/maintaining health status, or minimizing the impact of deterioration on the quality of life. Includes the preparation for treatment of a patient(s), the provision of specific techniques and procedures to a patient(s), support activities, monitoring of the patient's progress to evaluate the result of a specific intervention and the need to continue and/or modify treatment, and the related clinical documentation.	7SP10ZZ L=SW	7SP10ZZ L=SW	7SP10ZZ L=SW
CONSULTATION/COLLABORATION **(Must be linked to assessment and/or therapeutic intervention CCI code)** Formal or informal contact with personnel of the facility, community or other agencies for discussion regarding specific patients and/or significant others, in order to obtain, provide or exchange information relative to the patient's care. Includes any regularly scheduled/attended meetings of professionals to coordinate team efforts in services to patients, and the related clinical documentation	7SF15ZZ L=SW	7SF15ZZ L=SW	7SF15ZZ L=SW

NOTE: Location attribute code of SW (Social Work) is required for all Social Work intervention codes.

PSYCHOLOGY[1]

INTERVENTION AND DEFINITION	INTERVENTION CODE		
	LOW (0-60 MIN) Extent=4	MED (61-120 MIN) Extent=5	HIGH (120+ MIN) Extent=6
ASSESSMENT Activities for the sole purposes of evaluating the need for the service, the nature of the problem, the identification of the disorder or abnormality and the extent of services required. Is a formal, comprehensive process which generally uses specific assessment tools or methods to assess physical, psycho-social, cognitive abilities, medical requirements, environment and formal and informal supports. Includes preparation, collection of information, analysis of the assessment information, formulation of a working diagnosis, development of the care/treatment plan and documentation of assessment findings from the patient, family, employer, teacher, written records including medical charts and other sources. Excludes the ongoing evaluation associated with a specific intervention.	2AZ02ZZ L=PR	2AZ02ZZ L=PR	2AZ02ZZ L=PR
THERAPEUTIC INTERVENTION Activities carried out with a patient/significant other(s) that are aimed at improving/maintaining health status, or minimizing the impact of deterioration on the quality of life. Includes the preparation for treatment of a patient(s), the provision of specific techniques and procedures to a patient(s), support activities, monitoring of the patient's progress to evaluate the result of a specific intervention and the need to continue and/or modify treatment, and the related clinical documentation.	6AA10ZZ L=PR	6AA10ZZ L=PR	6AA10ZZ L=PR
CONSULTATION/COLLABORATION **(Must be linked to assessment and/or therapeutic intervention CCI code)** Formal or informal contact with personnel of the facility, community or other agencies for discussion regarding specific patients and/or significant others, in order to obtain, provide or exchange information relative to the patient's care. Includes any regularly scheduled/attended meetings of professionals to coordinate team efforts in services to patients, and the related clinical documentation	7SF15ZZ L=PR	7SF15ZZ L=PR	7SF15ZZ L=PR

[1]Psychology codes and Alberta-developed attributes are designated for services provided by non-mental health programs.

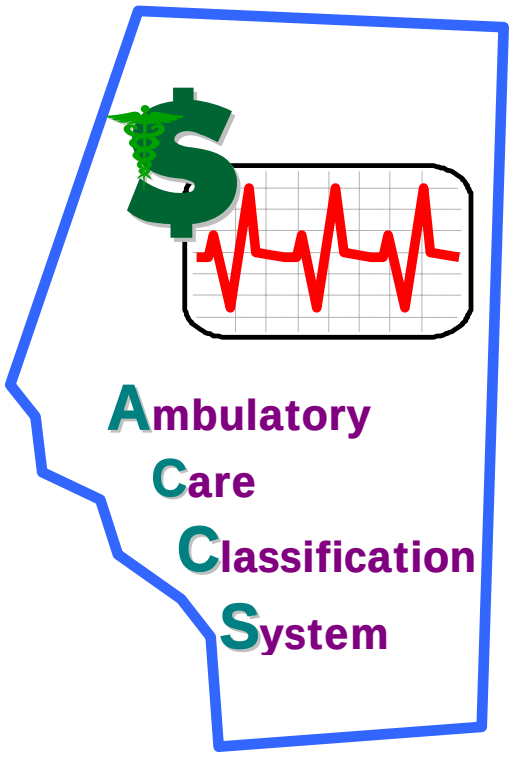
PSYCHOLOGY[1]

Neuropsychological Testing/Scoring Testing Type 1 (≤ 2 hours)	2AZ08ZZ E=1 L=PR
Testing Type 2 Half Day (> 2 hours and ≤ 4 hours)	2AZ08ZZ E=2 L=PR
Testing Type 3 Full Day (> 4 hours)	2AZ08ZZ E=3 L=PR

[1]Psychology codes and Alberta-developed attributes are designated for services provided by non-mental health programs.

NOTE: Location attribute code of PR (Psychology) is required for all Psychology intervention codes.

Alberta



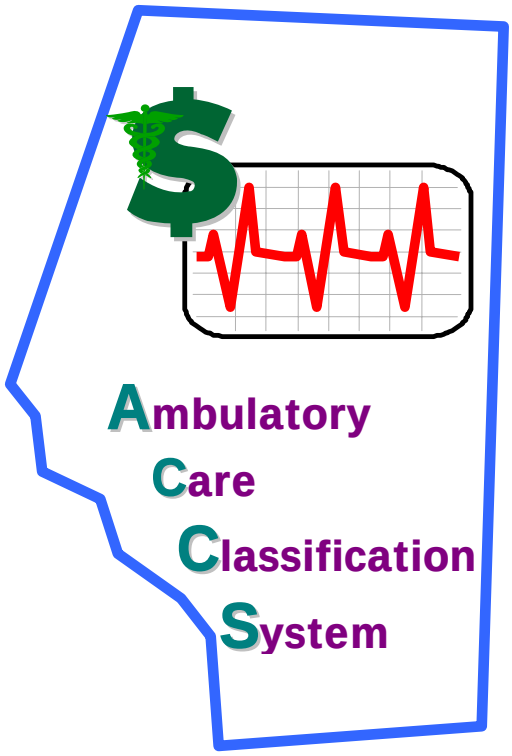
4. LIST OF ACCS INVESTIGATIVE TECHNOLOGIES

Effective April 2008

In this section of the documentation, a list of low and high cost investigative technologies is presented.

The list is available as a downloadable self-extracting file in Excel and Access format. To download the list, go to http://www.health.gov.ab.ca/.
Under News/Media/Resources select Publications. Next go to Ambulatory Care and Alberta Ambulatory Care Reporting Manual 2008.

Alberta
HEALTH AND WELLNESS



5. ACCS/CCI INTERVENTION CODES

Effective April 2008

ACCS/CCI Intervention Codes

This section includes lists of CCI codes and attribute codes that are mandatory to report for purposes of ACCS group assignment. The information is displayed in three tables including:

1. ACCS Intervention Codes
2. Mental Health Groups
3. ACCS Combination Code Groups

Following is a brief description of each table. Note that CCI codes excluded from any one table, that are mandatory to report, will be found in one of the other two tables.

ACCS Intervention Codes Table

Contains the majority of CCI codes that impact the ACCS grouper. A “1” in the Attribute Affects Grouper column indicates that the identified attribute codes in the Status, Location, and Extent columns are mandatory to report for proper ACCS group assignment. This table also includes the investigative technology codes.

Mental Health Group Table

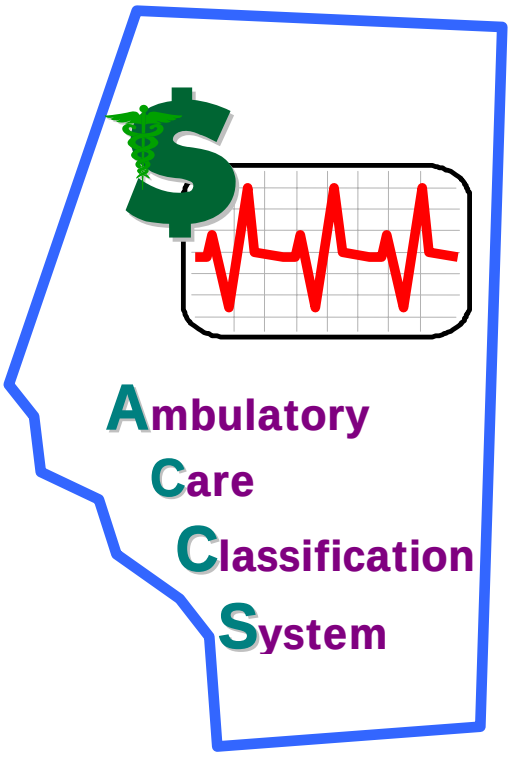
Contains all CCI codes relative to the provision of mental health services. Codes in this table have been assigned Alberta developed attributes that are mandatory to report for proper ACCS group assignment.

Combination Group Table

Contains all CCI codes relative to therapeutic service (e.g. physical therapy, clinical nutrition, social work) areas. Codes in this table have been assigned Alberta developed attributes that are mandatory to report for proper ACCS group assignment.

The tables are available as downloadable self-extracting files in Excel and Access format. To download the list, go to http://www.health.gov.ab.ca/.
Under News/Media/Resources select Publications. Next go to Ambulatory Care and Alberta Ambulatory Care Reporting Manual 2008.

Alberta



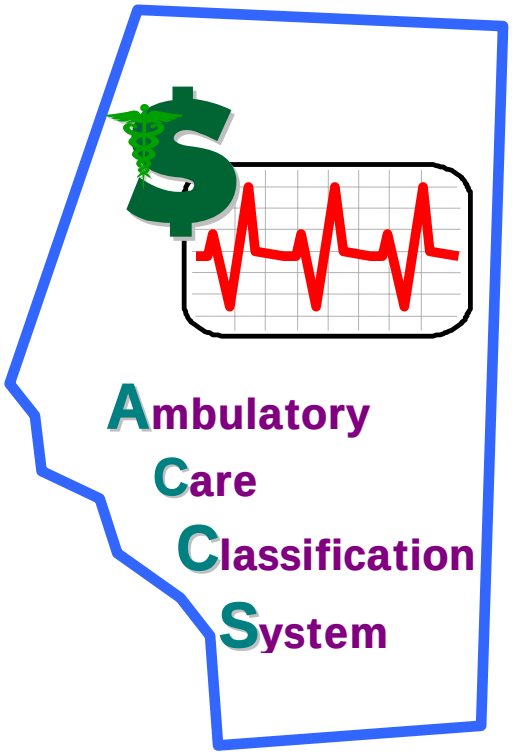
6. MIS PRIMARY ACCOUNTS VALID IN ACCS

Effective April 2008

In this section of the documentation, a list of MIS Primary Accounts is presented. The list includes accounts for ambulatory care services (713), diagnostic and therapeutic services (714), and community and social services (715).

The list is available as a downloadable self-extracting file in Excel and Access format. To download the list, go to http://www.health.gov.ab.ca/.
Under News/Media/Resources select Publications. Next go to Ambulatory Care and Alberta Ambulatory Care Reporting Manual 2008.

Alberta



7. INSTITUTION NUMBER LIST

Effective April 2008

Institution Number List

In this section of the documentation, an institution number list is presented.

Each provincial institution responsible for the provision of services to service recipients is identified by a five digit provincially assigned institution number.

The first digit identifies the province of the reporting institution which is 8 for Alberta.

The second digit identifies the level of care:

0=Acute

4=Free Standing Rehabilitation Centre

5=Free Standing Psychiatric Centre

6=Auxiliary

7=Nursing Home

8=Ambulatory

9=Sub Acute

The last three digits are the provincially assigned institution numbers.

The institution number list is also available as a downloadable self-extracting file in Excel format. To download the list, go to http://www.health.gov.ab.ca/.
Under News/Media/Resources select Publications. Next go to Ambulatory Care and Alberta Ambulatory Care Reporting Manual 2008.

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
80001					88001		001	7	Athabasca	Athabasca Healthcare Centre	
80002					88002		002	3	Banff	Mineral Springs Hospital	
80003					88003		003	7	Barrhead	Barrhead Healthcare Centre	
80005					88005		005	2	Bassano	Bassano Health Centre	
80006					88006		006	8	Beaverlodge	Beaverlodge Municipal Hospital	
					88008		008	3	Calgary	Richmond Road Diagnostic & Treatment Centre	Number effective September 1, 2006
80009					88009		009	1	Blairmore	Crowsnest Pass Health Centre	Facility previously called Crowsnest Pass Hospital. Name change effective September 7, 2006
80011					88011		011	2	Bow Island	Bow Island Health Centre	
80012					88012		012	7	Boyle	Boyle Healthcare Centre	
80014					88014		014	2	Brooks	Brooks Health Centre	
80015					88015		015	3	Calgary	Calgary Health Region Alberta Children's Hospital	
80016					88016		016	3	Calgary	Calgary Health Region Foothills Medical Centre	
80020					88020		020	3	Calgary	Calgary Health Region Rockyview General Hospital	
80021					88021		021	5	Camrose	St. Mary's Hospital	
80022					88022		022	3	Canmore	Canmore General Hospital	
80023					88023		023	1	Cardston	Cardston Health Centre	Facility previously called Cardston Hospital. Name change effective September 7, 2006

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
80025					88025		025	4	Castor	Our Lady of the Rosary Hospital	
80027					88027		027	3	Claresholm	Claresholm General Hospital	
					88028		028	1	Coaldale	Coaldale Health Centre	Facility previously called Coaldale Health Care Centre. Name change effective September 7, 2006
80029					88029		029	7	Cold Lake	Cold Lake Healthcare Centre	Name change effective April 1, 2005
80030					88030		030	4	Consort	Consort Hospital and Care Centre	
80031					88031		031	4	Coronation	Coronation Hospital and Care Centre	
80032					88032	89032	032	5	Daysland	Daysland Health Centre	
80033					88033		033	6	Devon	Devon General Hospital	
80034					88034		034	3	Didsbury	Didsbury District Health Services	
80035					88035		035	4	Drayton Valley	Drayton Valley Hospital and Care Centre	
80036					88036		036	4	Drumheller	Drumheller Health Centre	
80041					88041		041	6	Edmonton	Misericordia Community Hospital	
80042					88042		042	6	Edmonton	Grey Nuns Community Hospital	
80043					88043		043	6	Edmonton	Royal Alexandra Hospital	
80044					88044		044	6	Edmonton	University of Alberta Hospital	
80045					88045		045	7	Edson	Edson Healthcare Centre	Name change effective April 1, 2005
80046					88046		046	7	Elk Point	Elk Point Healthcare Centre	Name change effective April 1, 2005
80049					88049		049	8	Fairview	Fairview Health Complex	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
					88050		050	1	Fort MacLeod	Fort MacLeod Health Centre	Facility previously called Fort MacLeod Hospital. Name change effective September 7, 2006
80052					88052		052	6	Fort Saskatchewan	Fort Saskatchewan Health Centre	
80053					88053		053	9	Fort Vermilion	St. Theresa General Hospital	
80056					88056		056	8	Grande Prairie	Queen Elizabeth II Hospital	
80057					88057		057	4	Hanna	Hanna Health Centre	
80058					88058		058	5	Hardisty	Hardisty Health Centre	
80059					88059		059	8	High Prairie	High Prairie Health Complex	
80060					88060		060	3	High River	High River General Hospital	
80061					88061		061	7	Hinton	Hinton Healthcare Centre	Name change effective April 1, 2005
80063					88063		063	4	Innisfail	Innisfail Health Centre	
80065					88065		065	7	Jasper	Seton - Jasper Healthcare Centre	Name change effective April 1, 2005
80066					88066	89066	066	5	Killam	Killam Health Care Centre	
80067					88067		067	7	Lac La Biche	William J.Cadzow - Lac La Biche Healthcare Centre	Name change effective April 1, 2005
80068					88068		068	4	Lacombe	Lacombe Hospital and Care Centre	
80069					88069		069	5	Lamont	Lamont Health Care Centre	
80070					88070	89070	070	6	Leduc	Leduc Community Hospital	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
80071					88071	89071	071	1	Lethbridge	Chinook Regional Hospital	Facility previously called Lethbridge Regional Hospital. Name change effective September 7, 2006 Subacute beds effective February 5, 2007. No inpatient records are submitted to CIHI for facility 89071.
80074					88074		074	8	McLennan	Sacred Heart Community Health Centre	
80076					88076		076	8	Manning	Manning Community Health Centre	
80078					88078		078	7	Mayerthorpe	Mayerthorpe Healthcare Centre	
80079					88079		079	2	Medicine Hat	Medicine Hat Regional Hospital	
					88080		080	1	Milk River	Milk River Health Centre	Facility previously called Milk River Hospital. Name change effective September 7, 2006
80083					88083		083	4	Olds	Olds Hospital and Care Centre	
80084					88084		084	2	Oyen	Big Country Hospital	
80085					88085		085	8	Peace River	Peace River Community Health Centre	
80087					88087		087	1	Pincher Creek	Pincher Creek Health Centre	Facility previously called Pincher Creek Hospital. Name change effective September 7, 2006
80088					88088		088	4	Ponoka	Ponoka Hospital and Care Centre	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
80089					88089		089	5	Provost	Provost Health Centre	
80091					88091		091	1	Raymond	Raymond Health Centre	Facility previously called Raymond Hospital. Name change effective September 7, 2006
80092					88092		092	4	Red Deer	Red Deer Regional Hospital Centre	
80093					88093		093	4	Rimbey	Rimbey Hospital and Care Centre	
80094					88094		094	4	Rocky Mountain House	Rocky Mountain House Health Centre	
80095					88095		095	7	Smoky Lake	George McDougall - Smoky Lake Healthcare Centre	Name change effective April 1, 2005
80096					88096		096	8	Spirit River	Central Peace Health Complex	
80097					88097		097	4	Stettler	Stettler Hospital and Care Centre	
80099					88099		099	7	St. Paul	St. Therese - St. Paul Healthcare Centre	Name change effective April 1, 2005
80100					88100		100	1	Taber	Taber Health Centre	Facility previously called Taber Hospital. Name change effective September 7, 2006
80101					88101		101	4	Three Hills	Three Hills Health Centre	
80102					88102		102	5	Tofield	Tofield Health Centre	
80105					88105		105	5	Two Hills	Two Hills Health Centre	
80106					88106		106	8	Valleyview	Valleyview Health Centre	
80107					88107		107	5	Vegreville	St. Joseph's General Hospital	
80108					88108		108	5	Vermilion	Vermilion Health Centre	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
80109					88109		109	5	Viking	Viking Health Centre	
80111					88111		111	3	Vulcan	Vulcan Community Health Centre	
80112					88112		112	5	Wainwright	Wainwright Health Centre	
80113					88113		113	7	Westlock	Westlock Healthcare Centre	
80114					88114		114	4	Wetaskiwin	Wetaskiwin Hospital and Care Centre	
80116					88116		116	7	Whitecourt	Whitecourt Healthcare Centre	
80117					88117		117	9	Ft. McMurray	Northern Lights Regional Health Centre	
80118					88118		118	7	Slave Lake	Slave Lake Healthcare Centre	Name change effective April 1, 2005
80119					88119		119	4	Sundre	Sundre Hospital and Care Centre	
80120					88120		120	6	St. Albert	Sturgeon Community Hospital	
80121					88121		121	8	Grande Cache	Grande Cache Community Health Complex	Facility previously called Grande Cache General Hospital
80122					88122		122	6	Redwater	Redwater Health Centre	Facility previously called Redwater Healthcare Centre. Name change effective February 1, 2006
80123					88123		123	9	High Level	Northwest Health Centre	All active and auxiliary (86318) hospital services were transferred from the old High Level General Hospital location to the new replacement Northwest Health Centre.

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
80132					88132		132	8	Grimshaw	Grimshaw/Berwyn and District Community Health Centre	No inpatient abstracts are submitted to CIHI for this site
80133					88133		133	8	Fox Creek	Fox Creek Healthcare Centre	
80134					88134		134	3	Strathmore	Strathmore District Health Services	
80136					88136		136	7	Swan Hills	Swan Hills Healthcare Centre	
80139					88139		139	3	Black Diamond	Oilfields General Hospital	
80141					88141		141	7	Bonnyville	Bonnyville Healthcare Centre	Name change effective April 1, 2005
80144					88144		144	7	Desmarais	Wabasca/Desmarais Healthcare Centre	Name change effective April 1, 2005
					88145		145	9	Rainbow Lake	Rainbow Lake Health Centre	
80148					88148		148	3	Calgary	Calgary Health Region Peter Lougheed Centre	
					88149		149	6	Edmonton	Northeast Community Health Centre	
80150					88150		150	6	Stony Plain	WestView Health Centre - Stony Plain	
					88155		155	3	Calgary	South Calgary Health Centre	Effective Date: April 1, 2005
			86200				200	7	Westlock	Westlock Healthcare Centre	
			86201				201	3	Calgary	Bethany Care Centre	
			86202				202	3	Calgary	Carewest Crossbow	
			86203		88203	89203	203	3	Calgary	Carewest Glenmore Park	
			86204			89204	204	3	Calgary	Carewest Sarcee	Effective date for subacute number is December 12, 2005

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
			86205				205	5	Camrose	Louise Jensen Care Centre	Name change effective April 20, 2005. The Bethany Auxiliary Hospital (AUX #205) was closed on April 20, 2005 and was physically replaced by a new building at a different site location. Institution number remains the same.
			86206				206	1	Cardston	Cardston Health Centre	Facility previously called Cardston Hospital. Name change effective September 7, 2006
			86207		88207		207	3	Claresholm	Willow Creek Continuing Care Centre	
			86208				208	3	Didsbury	Didsbury District Health Services	
			86209				209	4	Drumheller	Drumheller Health Centre	
			86210				210	6	Edmonton	Allen Gray Continuing Care Centre	
			86211			89211	211	6	Edmonton	Good Samaritan Dr. Gerald Zetter Care Centre	
			86212			89212	212	6	Edmonton	Capital Care Norwood	
			86213			89213	213	6	Edmonton	St. Joseph's Auxiliary Hospital	
			86214				214	8	Grande Prairie	Queen Elizabeth II Hospital	
			86215				215	5	Killam	Killam Health Care Centre	
			86216				216	5	Lamont	Lamont Health Care Centre	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
			86217			89217	217	1	Lethbridge	St.Michael's Health Centre	Effective date for subacute number 89217 is September 19, 2006
			86218				218	5	Lloydminster	Dr. Cooke Extended Care Centre	
			86219				219	8	Peace River	Peace River Community Health Centre	
			86222				222	4	Rimbey	Rimbey Hospital and Care Centre	
			86223				223	4	Stettler	Stettler Hospital and Care Centre	
			86224				224	5	Vegreville	Vegreville Care Centre	Facility previously called Vegreville Long Term Care Centre
			86225				225	5	Wainwright	Wainwright Health Centre	
			86227				227	4	Wetaskiwin	Wetaskiwin Hospital and Care Centre	
			86228				228	8	Fairview	Fairview Health Complex	
			86229				229	6	Edmonton	Capital Care Lynnwood	
			86231			89231	231	6	Edmonton	Capital Care Grandview	
			86233		88233	89233	233	3	Calgary	Carewest Dr. Vernon Fanning Centre	
			86234				234	6	Edmonton	Capital Care Dickinsfield	
			86235		88235		235	7	Radway	Radway Continuing Care Centre	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
			86236				236	6	Edmonton	The Dianne and Irving Kipnes Centre for Veterans	Name change effective November 21, 2005. The Mewburn Veterans Centre (AUX #236) was closed on November 20, 2005 and was physically replaced by a new building at a different site location. Institution number remains the same.
			86237				237	2	Brooks	Brooks Health Centre	
			86238				238	4	Lacombe	Lacombe Hospital and Care Centre	
			86240		88240		240	3	Calgary	Calgary Health Region Colonel Belcher Care Centre	
			86241				241	3	High River	High River General Hospital	
			86243				243	2	Bow Island	Bow Island Health Centre	
			86244				244	4	Innisfail	Innisfail Health Centre	
			86246		88246		246	5	Mundare	Mary Immaculate Hospital	
			86249				249	6	Edmonton	Millwoods Shepherd's Care Centre	
			86250				250	1	Milk River	Milk River Health Centre	Facility previously called Milk River Hospital. Name change effective September 7, 2006
			86251			89251	251	6	Edmonton	St. Michael's Long Term Care Centre	
			86252				252	7	Athabasca	Athabasca Healthcare Centre	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
			86253				253	7	Lac La Biche	William J.Cadzow - Lac La Biche Healthcare Centre	Name change effective April 1, 2005
			86254				254	3	Canmore	Canmore General Hospital	
			86255				255	4	Coronation	Coronation Hospital and Care Centre	
			86256				256	4	Drayton Valley	Drayton Valley Hospital and Care Centre	
			86257				257	1	Pincher Creek	Pincher Creek Health Centre	Facility previously called Pincher Creek Hospital. Name change effective September 7, 2006
			86258				258	4	Three Hills	Three Hills Health Centre	
			86259				259	1	Fort MacLeod	Fort MacLeod Health Centre	Facility previously called Fort MacLeod Hospital. Name change effective September 7, 2006
			86260				260	8	Spirit River	Central Peace Health Complex	
			86261				261	3	Black Diamond	Oilfields General Hospital	
			86263				263	7	Bonnyville	Bonnyville Healthcare Centre	Name change effective April 1, 2005
			86264				264	4	Ponoka	Ponoka Hospital and Care Centre	
			86265				265	7	Smoky Lake	George McDougall - Smoky Lake Healthcare Centre	Name change effective April 1, 2005
			86266				266	1	Taber	Taber Health Centre	Facility previously called Taber Hospital. Name change effective September 7, 2006
			86267				267	5	Tofield	Tofield Health Centre	
			86268				268	5	Two Hills	Two Hills Health Centre	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
			86269				269	7	St. Paul	St.Therese - St. Paul Healthcare Centre	Name change effective April 1, 2005
			86270				270	8	Grand Cache	Grande Cache Community Health Complex	Facility previously called Grande Cache General Hospital
			86271				271	7	Cold Lake	Cold Lake Healthcare Centre	Name change effective April 1, 2005
			86272				272	2	Oyen	Big Country Hospital	
			86273				273	3	Carmangay	Little Bow Continuing Care Centre	
			86274				274	1	Blairmore	Crowsnest Pass Health Centre	Facility previously called Crowsnest Pass Hospital. Name change effective September 7, 2006
			86275				275	4	Olds	Olds Hospital and Care Centre	
			86277				277	1	Raymond	Raymond Health Centre	Facility previously called Raymond Hospital. Name change effective September 7, 2006
			86278				278	3	Banff	Mineral Springs Hospital	
			86279				279	7	Mayerthorpe	Mayerthorpe Healthcare Centre	
			86282				282	1	Coaldale	Coaldale Health Centre	Facility previously called Coaldale Health Care Centre. Name change effective September 7, 2006
			86284				284	2	Bassano	Bassano Health Centre	
			86286				286	5	Vermilion	Vermilion Health Centre	
			86287				287	6	Stony Plain	WestView Health Centre - Stony Plain	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
			86290				290	5	Provost	Provost Health Centre	
			86293				293	5	Camrose	Bethany Meadows	Change effective November 1, 2003. Auxiliary services transferred from Rosehaven Care Centre - Hawthorne to the new Bethany Meadows facility. Hawthorne wing was demolished.
			86294				294	9	Ft. McMurray	Northern Lights Regional Health Centre	
			86295				295	3	Vulcan	Vulcan Community Health Centre	
			86297				297	7	Elk Point	Elk Point Healthcare Centre	Name change effective April 1, 2005
			86298		88298	89298	298	6	Edmonton	Edmonton General Continuing Care Centre	
			86299				299	8	Valleyview	Valleyview Health Centre	
			86300				300	4	Bentley	Bentley Care Centre	
			86301				301	1	Standoff	Kai Nai Continuing Care Centre (Blood Indian Hospital)	
			86303				303	4	Sundre	Sundre Hospital and Care Centre	
			86304		88304		304	4	Trochu	St.Mary's Health Care Centre	
			86306				306	4	Consort	Consort Hospital and Care Centre	
			86308				308	4	Castor	Our Lady of the Rosary Hospital	
			86310				310	5	Hardisty	Hardisty Health Centre	
			86311				311	6	Devon	Devon General Hospital	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
			86312				312	7	Jasper	Seton - Jasper Healthcare Centre	Name change effective April 1, 2005
			86313		88313		313	4	Breton	Breton Health Centre	
			86314		88314		314	5	Mannville	Mannville Care Centre	Facility previously called Mannville Health Centre
			86315				315	8	Manning	Manning Community Health Centre	
			86316				316	7	Slave Lake	Slave Lake Healthcare Centre	Name change effective April 1, 2005
			86317				317	9	Fort Vermilion	St.Theresa General Hospital	
			86318				318	9	High Level	Northwest Health Centre	All active (80123 and 88123) and auxiliary hospital services were transferred from the old High Level General Hospital location to the new replacement Northwest Health Centre.
			86319		88319	89319	319	5	Bashaw	Bashaw Care Centre	88319,89319 number valid April 1, 2004
					88391		391	3	Okotoks	Okotoks Health and Wellness Centre	Number effective April 1, 2007
					88393		393	3	Calgary	8th & 8th Health Centre	Number effective April 1, 2007
					88394		394	3	Calgary	Sheldon M Chumir Centre	Number effective April 1, 2007
					88395		395	3	Calgary	Sunridge Medical Gallery	Number effective April 1, 2007
				87400			400	6	Edmonton	Capital Care Norwood	Dr. Angus McGugan Pavilion
				87401			401	6	Edmonton	The Good Samaritan Southgate Care Centre	Good Samaritan - Southgate Nursing Home

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
				87402			402	1	Blairmore	Crowsnest Pass Health Centre	Facility previously called Crowsnest Pass Hospital. Name change effective September 7, 2006
				87403			403	4	Stettler	Stettler Hospital and Care Centre	
				87404			404	1	Cardston	Grandview Nursing Home	
				87407			407	3	Calgary	Beverly Centre - Glenmore	The Beverly Centre Beverly Nursing Home
				87408			408	3	Calgary	Extendicare Hillcrest	Hillcrest Nursing Home Hillcrest Care Centre Extendicare Nursing Home
				87409			409	3	Calgary	Bow Crest Care Centre	Bow-Crest Nursing Home Bow-Crest Care Centre
				87410			410	3	Calgary	Forest Grove Care Centre	
				87411			411	3	Calgary	Bow View Manor	
				87412			412	3	Calgary	Intercare Brentwood Care Centre	Brentwood Care Centre Brentwood Nursing Home
				87413			413	3	Calgary	Mount Royal Care Centre	Calgary Central Park Lodge
				87414			414	1	Fort MacLeod	Extendicare Fort MacLeod	Extendicare Nursing Home
				87416			416	3	Calgary	Carewest George Boyack	George Boyack Nursing Home
				87417			417	5	Vermilion	Vermilion Health Centre	
				87418			418	5	Lloydminster	Dr. Cooke Extended Care Centre	
				87419			419	4	Red Deer	Valley Park Manor (Red Deer)	Valley Park Manor

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
				87420			420	3	Calgary	Extendicare Cedars Villa	Cedars Villa Nursing Home Extendicare Nursing Home Cedar Village Cedars Villa Care Centre
				87421			421	6	Edmonton	South Terrace Continuing Care Centre	Edmonton Central Park Lodge Nursing Home
				87422			422	1	Lethbridge	Extendicare Lethbridge	Extendicare Nursing Home
				87423			423	3	Calgary	Intercare Chinook Care Centre	Chinook Nursing Home Chinook Care Centre
				87424			424	2	Medicine Hat	South Country Village	Sunnyside Nursing Home
				87425			425	5	Lamont	Lamont Health Care Centre	Lamont Continuing Care Centre
				87426			426	7	Smoky Lake	Smoky Lake Continuing Care Centre	Name change effective April 1, 2005
				87430			430	7	Mayerthorpe	Extendicare Mayerthorpe	Mayerthorpe Extendicare Extendicare Nursing Home Mayerthorpe
				87431			431	3	Calgary	Glamorgan Care Centre	Glamorgan Nursing Home
				87433			433	7	Athabasca	Extendicare Athabasca	Athabasca Extendicare
				87434			434	8	Grande Prairie	Grande Prairie Care Centre	
				87435			435	6	Edmonton	Hardisty Nursing Home	
				87436			436	6	Edmonton	Extendicare Holyrood	Extendicare Nursing Home (Edmonton South)
				87437			437	2	Medicine Hat	South Ridge Village	Good Samaritan South Ridge Village
				87438			438	6	Edmonton	Jubilee Lodge Nursing Home	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
				87439			439	8	High Prairie	J.B. Wood Continuing Care Centre	Facility previously called J.B. Wood Nursing Home. Name change effective September 12, 2006. Previous facility name was High Prairie Health Complex
				87441			441	3	Calgary	Father Lacombe Care Centre	Father Lacombe Nursing Home
				87442			442	2	Brooks	Brooks Health Centre	
				87443			443	4	Linden	Linden Nursing Home	
				87445			445	4	Ponoka	Northcott Care Centre (Ponoka)	Northcott Care Centre Northcott Lodge Nursing Home
				87446			446	3	Calgary	Beverly Centre - Lake Midnapore	
				87447			447	3	Vulcan	Extendicare Vulcan	Extendicare Vulcan Nursing Home
				87448			448	3	Calgary	Mayfair Care Centre	Mayfair Nursing Home
				87449			449	1	Lethbridge	Edith Cavell Care Centre	Edith Cavell Nursing Home
				87450			450	7	Bonnyville	Extendicare Bonnyville	Extendicare Nursing Home (Bonnyville)
				87452			452	6	Leduc	Extendicare Leduc	Extendicare Leduc Nursing Home
				87453			453	2	Medicine Hat	The Valleyview	Valleyview Continuing Care Centre
				87454			454	6	Ft. Saskatchewan	Rivercrest Care Centre	Rivercrest Lodge Nursing Home
				87455			455	4	Red Deer	Red Deer Nursing Home	
				87456			456	2	Medicine Hat	Riverview Care Centre	Central Park Lodge Central Care Nursing Home Central Park Lodge - Riverview

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
				87457			457	7	St. Paul	Extendicare St. Paul	St.Paul Extendicare Extendicare Nursing Home (St. Paul)
				87459			459	3	Calgary	Intercare Southwood Care Centre	Southwood Care Centre Southwood Nursing Home
				87460			460	5	Viking	Viking Extendicare	Viking Nursing Home
				87463			463	5	Galahad	Galahad Care Centre	Facility previously called Galahad Health Centre
				87464			464	6	Stony Plain	The Good Samaritan Stony Plain	Good Samaritan Nursing Home
				87465			465	6	Edmonton	Jasper Place Continuing Care Centre	Jasper Place Central Park Lodge
				87466			466	6	Edmonton	Venta Care Centre	Previously called Venta Nursing Home. Name change effective September 1, 2004
				87467			467	7	Barrhead	Dr. W. R. Keir - Barrhead Continuing Care Centre	Name change effective April 1, 2005
				87469			469	6	Sherwood Park	Sherwood Park Care Centre	Sherwood Park Nursing Home
				87471			471	3	Calgary	Carewest Sarcee	Sarcee Auxiliary Hospital Sarcee Nursing Home
				87472			472	3	Airdrie	Bethany Care Centre - Airdrie	Airdrie Bethany Nursing Home
				87473			473	5	Two Hills	Two Hills Health Centre	
				87476			476	4	Hanna	Hanna Health Centre	
				87477			477	4	Wetaskiwin	Wetaskiwin Hospital and Care Centre	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
				87478			478	6	Edmonton	Extendicare Somerset	Extendicare Nursing Home (Edmonton North)
				87480			480	7	Edson	Edson Healthcare Centre	Name change effective April 1, 2005
				87481			481	6	Edmonton	Capital Care Lynnwood	Roger Parker Pavilion
				87483			483	6	Edmonton	Capital Care Dickinsfield	
				87484			484	6	Leduc	Salem Manor Nursing Home	
				87485			485	6	Edmonton	St. Michael's Long Term Care Centre	
				87486			486	8	Hythe	Hythe Continuing Care Centre	Hythe Nursing Home
				87487			487	6	Edmonton	Millwoods Shepherds Care Centre	Millwoods Shepherd's Care
				87488			488	4	Drayton Valley	Drayton Valley Hospital and Care Centre	
				87490			490	3	Strathmore	Strathmore District Health Services	
				87491			491	1	Taber	Taber Health Centre	Facility previously called Taber Hospital. Name change effective September 7, 2006
				87492			492	3	Calgary	Bethany Harvest Hills	Bethany Harvest Hills Alzheimer's Care Centre
				87493			493	9	Lacrete	La Crete Continuing Care Centre	LaCrete (Community) Health Centre LaCrete Health Centre Nursing Home
				87494			494	5	Tofield	Tofield Health Centre	
				87496			496	3	Claresholm	Willow Creek Continuing Care Centre	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
				87497			497	6	Sherwood Park	Capital Care Strathcona	Strathcona Care Centre Nursing Home Note: An incorrect Institution Number for the nursing home was previously displayed as 86497. The correct number is 87497. This change was identified on the June 2007 Institution Number update version.
				87498			498	3	Cochrane	Bethany Care Centre - Cochrane	
				87550			550	3	Calgary	Carewest Signal Pointe	Signal Pointe Alzheimer's Care Centre
				87551			551	3	Calgary	Carewest Royal Park	Carewest Royal Park Care Centre
				87552			552	3	Calgary	McKenzie Towne Care Centre	
				87553			553	3	Calgary	Wentworth Court	Wentworth Manor - The Court Wentworth Court Care Centre
				87554			554	3	Calgary	Holy Cross	Holy Cross Chronic Care Centre
				87555			555	2	Brooks	Orchard Manor	Orchard Manor Continuing Care Centre
				87557			557	6	Evansburg	The Good Samaritan Pembina Village	
				87558			558	6	Edmonton	Devonshire Care Centre	
			86559				559	8	Grimshaw	Grimshaw/Berwyn and District Community Health Centre	
				87561			561	4	Sylvan Lake	Bethany Sylvan Lake	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
				87562			562	3	Calgary	Newport Harbour	Newport Harbour Care Centre Number effective April 05, 2004
				87563			563	2	Medicine Hat	Club Sierra	Club Sierra at River Ridge Number effective August 2004
				87564			564	4	Rocky Mountain House	Clearwater Centre (Rocky Mountain House)	Clearwater Centre Number effective March 22, 2004
				87565			565	4	Red Deer	Bethany CollegeSide (Red Deer)	Bethany Collegeside Number effective May 7, 2004
			86566				566	5	Camrose	Rosehaven Care Centre	Number effective April 01, 2004. The Rosehaven Care Centre is a recognized province-wide service. This specialized behavior management program operates as an auxiliary hospital service that has been assigned a new registration number to be used for all future Rosehaven Provincial Program reporting.
				87567			567	6	Edmonton	Edmonton Chinatown Care Centre	Number effective September 2004 Name changed from Hong Lok Care Centre March 1, 2005
				87569			569	6	Edmonton	Miller Crossing Care Centre	Number effective November 15, 2004
				87570			570	3	Calgary	Intercare Millrise Care Centre	Intercare at Millrise Care Centre Number effective February 15, 2005

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
				87571			571	3	Calgary	Wing Kei Care Centre	Wing Kei Nursing Home Number effective May 2, 2005
				87610			610	6	Edmonton	Kensington Village Continuing Care Centre	
				87611			611	6	St. Albert	Citadel Care Centre	Number effective Nov 7, 2005
			86612				612	6	Redwater	Redwater Health Centre	Number effective February 1, 2006
				87613			613	6	Edmonton	Touchmark at Wedgewood	Number effective February 12, 2007
				87614			614	6	Edmonton	Millwoods Centre	Good Samaritan Society - Millwoods Centre The Good Samaritan Millwoods Centre Number effective April 1, 2006
			86615			89615	615	6	Edmonton	Youville Auxiliary Hospital (Grey Nuns) of St. Albert	Number effective March 21, 2007
				87616			616	8	McLennan	Manoir du Lac	Number effective May 1, 2007
					88625		625	3	Calgary	Kensington Clinic	
					88626		626	6	Edmonton	Morgentaler Clinic	
					88650		650	3	Calgary	Calgary Health Region at Sunridge Mall	Number effective October 2, 2006
					88759		759	7	Glendon	Glendon Health Centre	
					88760		760	5	Myrnam	Myrnam Health Centre	
					88761		761	7	Vilna	Our Lady's Health Centre	
					88762		762	5	Willingdon	Mary Immaculate Health Centre	
					88763		763	3	Calgary	Calgary Retina Consultants	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
					88764		764	3	Calgary	Cardiac Wellness Institute	
					88765		765	9	Zama City	Zama City Community Health Centre	
					88766		766	9	Paddle Prairie	Paddle Prairie Community Health Centre	
					88767		767	6	Sherwood Park	Health First Strathcona	
					88768		768	1	Picture Butte	Piyami Community Health Centre	Number effective June 28, 2004
					88769		769	3	Calgary	Sonus Rockyview Hearing Balance Clinic	Number effective November 1, 2004
					88770		770	1	Magrath	Magrath Health Centre	Number effective February 1, 2006 Facility previously called Magrath Community Health and Assisted Living Centre. Name change effective September 7, 2006.
					88800		800	6	Edmonton	Buski Eye Centre & Surgical Suite	
					88802		802	6	Edmonton	David Climenhaga Prof. Corp.	
					88803		803	6	Edmonton	Gimbel Eye Centre	
					88805		805	6	Edmonton	Johnson, Royce MD	
					88806		806	6	Edmonton	Alberta Eye Institute	
					88807		807	6	Edmonton	Don Groot Prof./Dermasurgery Centre	
					88808		808	6	Edmonton	Plastic & Cosmetic Laser Surgical Centre	
					88809		809	3	Calgary	Gimbel Eye Centre	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
					88810		810	3	Calgary	Holy Cross Surgical Services	
					88811		811	3	Calgary	Mitchell Eye Centre	
					88812		812	3	Calgary	Rocky Mountain Surgical Centre	
					88814		814	3	Calgary	Surgical Centre Inc. Glenmore	
					88817		817	3	Calgary	South Calgary Maxillofacial Surgery	
					88818		818	3	Calgary	Wakeham, Donald MD	
					88819		819	3	Calgary	Vincelli MD	
					88820		820	3	Calgary	Marlborough Surgicentre	
					88821		821	3	Calgary	Royal View Surgicentre	
					88822		822	6	Edmonton	Kingsway Oral Surgery	
					88823		823	6	Edmonton	South Edmonton Oral Surgery	
					88824		824	6	Edmonton	Kruetz, Randall MD	
					88825		825	6	Edmonton	Alberta Surgical Centre	Facility previously called Coronation Day Surgery Centre Ltd. Name change effective April 17, 2007.
					88826		826	3	Calgary	Anaesthesia Centre for Dentistry	
80827					88827		827	3	Calgary	Health Resources Group Inc.	80827 number effective November 1, 2004
					88828		828	3	Calgary	Ashenhurst, Michael E. MD	
					88829		829	6	Edmonton	Renew Oral and Facial Surgical Centre	Number effective October 2005
					88900		900	6	Edmonton	Dental Surgery Group	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
					88902		902	6	Edmonton	Lyka, Barry MD	
					88904		904	3	Calgary	Laser Rejuvenation Centre/Spa	
					88905		905	3	Calgary	Remington Laser Dermatology	
					88906		906	3	Calgary	Storwick, Greg MD	
					88908		908	3	Calgary	Calgary Sleep Institute	
					88909		909	3	Calgary	HBOT Clinic	
					88911		911	1	Lethbridge	Murray, Brian MD	
					88912		912	1	Lethbridge	Hall, Paul MD	
					88913		913	4	Red Deer	Maslove, Stuart MD Prof. Corp.	
					88914		914	4	Red Deer	Nye, G. MD	
					88915		915	6	Edmonton	Bochinski, M. MD	
					88916		916	6	Edmonton	Alberta Retina Consultants M. Greve & B. Hinz MDs	
					88917		917	6	Edmonton	Alberta Hip and Knee Clinic	Number effective October 16, 2006
					88918		918	3	Calgary	Forzani Charities Colon Cancer Screening Centre	Number effective December 1, 2007
					88922		922	3	Calgary	Airdrie Regional Health Centre	Number effective December 1, 2007
Rehabilitation Institution											
	84040				88040	89040	040	6	Edmonton	Glenrose Rehabilitation Hospital	

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
Psychiatric Facilities											
		85668			88668		668	1	Raymond	Raymond Care Centre	Although Raymond Care Centre was operational previously, number 85668 was added to the Institution Number List effective April 1, 2007. No inpatient records are submitted to CIHI for this facility.
		85669			88669		669	3	Claresholm	Claresholm Centre for Mental Health and Addictions	Name change effective October 1, 2006. Previously called Claresholm Care Centre No inpatient abstracts are submitted to CIHI for this site
		85137					137	6	Edmonton	Alberta Hospital Edmonton	
		85138					138	4	Ponoka	The Centennial Centre for Mental Health and Brain Injury	Name change effective October 1, 2006. Previously called Alberta Hospital Ponoka
		85572					572	3	Calgary	Southern Alberta Forensic Psychiatric Centre	Number effective June 1, 2005
Cancer Facilities											
80038					88038		038		Edmonton	Cross Cancer Institute	
					88601		601		Calgary	Tom Baker Cancer Centre	
					88602		602		Red Deer	Central Alberta Cancer Centre - Red Deer	
					88603		603		Lethbridge	Lethbridge Cancer Centre	

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					88604		604		Medicine Hat	Medicine Hat Cancer Centre	
					88605		605		Grande Prairie	Grande Prairie Cancer Centre	
					88638		638	7	Barrhead	Barrhead Community Cancer Centre	Number effective September 2007
					88639		639	7	Bonnyville	Bonnyville Community Cancer Centre	Number effective September 2007
					88640		640	5	Camrose	Camrose Community Cancer Centre	Number effective September 2007
					88641		641	9	Fort McMurray	Fort McMurray Community Cancer Centre	Number effective September 2007
					88642		642	7	Hinton	Hinton Community Cancer Centre	Number effective September 2007
					88643		643	8	Peace River	Peace River Community Cancer Centre	Number effective September 2007
					88645		645	4	Drayton Valley	Drayton Valley Community Cancer Centre	Number effective September 2007
					88646		646	4	Drumheller	Drumheller Community Cancer Centre	Number effective September 2007
					88647		647	3	High River	High River Community Cancer Centre	Number effective September 2007
					88648		648	3	Canmore	Bow Valley Community Cancer Centre	Number effective September 2007
Non-Hospital Regional Service Delivery Organization											
					88320		320	1			
					88321		321	2			
					88322		322	3			
					88323		323	4			

Acute Care Institution	Free Standing Rehab Centre	Free Standing Psychiatric Centre	Auxiliary Institution	Nursing Home Institution	Ambulatory Care Services	Sub Acute Care Services	Institution Registration Number*	RHA #	Location	Institution Name	Other Names/ Comments
					88324		324	5			
					88325		325	6			
					88326		326	7			
					88327		327	8			
					88328		328	9			
Note: Only where there is no provincially assigned institution number available should the following be reported											
							88999			Out-Of-Province Ambulatory Care	
							89995			Nursing Home	
							89996			Unknown/Unclassified Health Institution	
							89997			Home Care	
							89998			Senior Citizen Lodge	
							89999			Out-Of-Province/Country Acute Care Hosp	

Re: Stollery Children's Hospital

Re: Stollery Children's Hospital
On October 29, 2001 the Ministry approved Institution number 153 to the Stollery Children's Hospital. However, for purpose of reporting patient care activity, Institution number 153 will be considered to be a Non-Reporting Institution since the Stollery will continue to report under the University of Alberta Hospital Institution number 044.

Re: Lloydminster Hospital

Data for Alberta residents receiving services in Lloydminster Hospital will be made available by CIHI. The Lloydminster Hospital institution number is 073.
The Lloydminster Community Cancer Centre institution number is 644.

These numbers should NOT be used for reporting in Alberta.