STATE OF CALIFORNIA—OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION

REGULAR

per agency request

(See instructions on reverse)

For use by Secretary of State only

ENDORSED FILED
IN THE OFFICE OF
2014 SEP -4 PM 2:29
DEBRA BOWEN
SECRETARY OF STATE

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z- 2014-0527-02	2014-0723-01 S	

For use by Office of Administrative Law (OAL) only

2014 JUL 23 PM 12:31
OFFICE OF ADMINISTRATIVE LAW

NOTICE | REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY: Office of Statewide Health Planning and Development

AGENCY FILE NUMBER (If any):

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn	2014, 232	6/6/2014

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S): OSHPD Patient Data Reporting Program Updates

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S):

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)

ADOPT:

AMEND: 97215, 97225, 97226, 97227, 97228, 97229, 97231, 97244, 97247, 97248, 97258, 97259, 97260, 97261, 97264

TITLE(S): 22

REPEAL:

3. TYPE OF FILING

- ☒ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☐ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ File & Print
- ☐ Other (Specify)
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☐ Effective on filing with Secretary of State
- ☐ §100 Changes Without Regulatory Effect
- ☒ Effective other (Specify): October 1, 2014-written request attached

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☒ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify)

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Peter Won	(916) 326-3800		Peter.Won@oshpd.ca.gov

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE: Ron Spingarn

DATE: 07/22/14

TYPED NAME AND TITLE OF SIGNATORY: Ron Spingarn, Deputy Director

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

SEP 04 2014

Office of Administrative Law

State of California
Office of Administrative Law

In re:
Office of Statewide Health Planning and Development

Regulatory Action:

Title 22, California Code of Regulations

Adopt sections:
Amend sections: 97215, 97225, 97226, 97227, 97228, 97229, 97231, 97244, 97247, 97248, 97258, 97259, 97260, 97261, 97264
Repeal sections:

NOTICE OF APPROVAL OF REGULATORY ACTION

Government Code Section 11349.3

OAL File No. 2014-0723-01 S

This rulemaking by the Office of Statewide Health Planning and Development makes changes to the patient data reporting requirements in Title 22, of the California Code of Regulations. These changes include: 1) updates to inpatient and outpatient disposition codes to conform to national standards and revisions to the Format and File Specifications that are incorporated by reference; 2) the addition of a principal diagnosis code; 3) removal of out of date reporting requirements; and 4) delaying the implementation of ICD-10 from October 1, 2014 to October 1, 2015 in order to account for the delay in implementation of ICD-10 at the Federal level.

OAL approves this regulatory action pursuant to section 11349.3 of the Government Code. This regulatory action becomes effective on 10/1/2014.

Date: 9/4/2014

Kevin D. Hull
Senior Attorney

For: DEBRA M. CORNEZ
Director

Original: Robert David
Copy: Peter Won

oshpd Office of Statewide Health Planning and Development

Healthcare Information Division
400 R Street, Suite 250
Sacramento, California 95811-6213
(916) 326-3800
Fax (916) 324-9242
www.oshpd.ca.gov

Final Amendments to Regulations

CALIFORNIA CODE OF REGULATIONS

TITLE 22, DIVISION 7, CHAPTER 10, ARTICLE 8: PATIENT DATA REPORTING REQUIREMENTS

Sections 97215, 97225, 97226, 97227, 97228, 97229, 97231, 97244, 97247, 97248, 97258, 97259, 97260, 97261, and 97264

97215. Format.

(a) Hospital Discharge Abstract Data reports for discharges occurring on or after July 1, 2008 up to and including June 30, 2014 shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Inpatient Data, as revised on March 20, 2008 and hereby incorporated by reference. For discharges occurring on or after July 1, 2014 up to and including September 30, 2014, Hospital Discharge Abstract Data reports shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Inpatient Data as revised on January 1, 2014 and hereby incorporated by reference. ~~This document specifies instructions for discharges occurring July 1, 2014 to September 30, 2014 and specifies separate instructions for discharges occurring July 1, 2014 to September 30, 2014 and specifies instructions for discharges occurring on and after October 1, 2014.~~ For discharges occurring on or after October 1, 2014, Hospital Discharge Abstract Data reports shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Inpatient Data as revised on April 14, 2014 and hereby incorporated by reference.

(b) Emergency Care Data reports for encounters occurring on or after January 1, 2009 up to and including December 31, 2014~~September 30, 2014~~ shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Care and Ambulatory Surgery Data, as revised on March 20, 2008 and hereby incorporated by reference. ~~For encounters occurring on or after October 1, 2014, Emergency Care Data reports shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Care and Ambulatory Surgery Data, as revised on January 1, 2014 and hereby incorporated by reference.~~ For encounters occurring on or after January 1, 2015, Emergency Care Data reports shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Care and Ambulatory Surgery Data, as revised on April 14, 2014 and hereby incorporated by reference.

(c) Ambulatory Surgery Data reports for encounters occurring on or after January 1, 2009 up to and including December 31, 2014~~September 30, 2014~~ shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Care and Ambulatory Surgery Data, as revised on March 20, 2008. ~~For encounters occurring on or after October 1, 2014, Ambulatory Surgery Data reports shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Care and Ambulatory Surgery Data, as revised on January 1, 2014.~~ For encounters occurring on or after January 1, 2015, Ambulatory Surgery Data reports shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Care and Ambulatory Surgery Data, as revised on April 14, 2014 and hereby incorporated by reference.

(d) The Office's Format and File Specifications for MIRCal Online Transmission as named in (a), (b), and (c) are available for download from the MIRCal website. The Office will make a hardcopy of either set of Format and File Specifications for MIRCal Online Transmission available to a reporting facility or designated agent upon request.

Note: Authority cited: Section 128810, Health and Safety Code.
Reference: Sections 128735, 128736 and 128737, Health and Safety Code.

97225. Definition of Data Element for Inpatients—Principal Diagnosis and Present on Admission Indicator.

(a)(1) For discharges occurring up to and including September 30, ~~2014~~2015: The patient's principal diagnosis, defined as the condition established, after study, to be the chief cause of the admission of the patient to the facility for care, shall be coded according to the ICD-9-CM.

(2) For discharges occurring on and after October 1, ~~2014~~2015: The patient's principal diagnosis, defined as the condition established, after study, to be the chief cause of the admission of the patient to the facility for care, shall be coded according to the ICD-10-CM.

(b) Effective with discharges on or after July 1, 2008, whether the patient's principal diagnosis was present on admission shall be reported as one of the following:

(1) Y. Yes. Condition was present at the time of inpatient admission.

(2) N. No. Condition was not present at the time of inpatient admission.

(3) U. Unknown. Documentation is insufficient to determine if the condition was present at the time of inpatient admission.

(4) W. Clinically undetermined. Provider is unable to clinically

determine whether the condition was present at the time of inpatient admission.

(5) (blank) Exempt from present on admission reporting.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97226. Definition of Data Element for Inpatients—Other Diagnosis and Present on Admission Indicator.

(a)(1) For discharges occurring up to and including September 30, ~~2014~~2015: The patient's other diagnoses are defined as all conditions that coexist at the time of admission, that develop subsequently during the hospital stay, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay are to be excluded. Diagnoses shall be coded according to the ICD-9-CM. ICD-9-CM codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) and codes from Morphology of Neoplasms (M800-M997 codes) shall not be reported as other diagnoses.

(2) For discharges occurring on and after October 1, ~~2014~~2015: The patient's other diagnoses are defined as all conditions that coexist at the time of admission, that develop subsequently during the hospital stay, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay are to be excluded. Diagnoses shall be coded according to the ICD-10-CM. ICD-10-CM codes from External Causes of Morbidity (V00-Y99) shall not be reported as other diagnoses.

(b) Effective with discharges on or after July 1, 2008, whether the patient's other diagnosis was present on admission shall be reported as one of the following:

(1) Y. Yes. Condition was present at the time of inpatient admission.

(2) N. No. Condition was not present at the time of inpatient admission.

(3) U. Unknown. Documentation is insufficient to determine if the condition was present at the time of inpatient admission.

(4) W Clinically undetermined. Provider is unable to clinically determine whether the condition was present at the time of inpatient admission.

(5) (blank) Exempt from present on admission reporting.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97227. Definition of Data Element for Inpatients—External Causes of Morbidity and Present on Admission Indicator.

(a)(1) For discharges up to and including September 30, ~~2014~~2015: The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable. An E-code is to be reported on the record for the first episode of care reportable to the Office during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. If the E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the discharge record. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect.

(2) For discharges occurring on and after October 1, ~~2014~~2015: The external causes of morbidity shall be coded using the ICD-10-CM External Causes of Morbidity (V00 – Y99). The external cause of morbidity that resulted in the injury or health condition shall be listed first. Additional cause of morbidity codes shall be reported if necessary to describe the mechanisms that contributed to, or the causal events surrounding, the injury or health condition.

(b) For discharges on or after July 1, 2008, whether the patient's external cause of injury was present on admission shall be reported as one of the following:

(1) Y. Yes. Condition was present at the time of inpatient admission.

(2) N. No. Condition was not present at the time of inpatient admission.

(3) U. Unknown. Documentation is insufficient to

determine if the condition was present at the time of inpatient admission.

(4) W Clinically undetermined. Provider is unable to clinically determine whether the condition was present at the time of inpatient admission.

(5) (blank) Exempt from present on admission reporting.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97228. Definition of Data Element for Inpatients—Principal Procedure and Date.

(a) For discharges occurring up to and including September 30, ~~2014~~2015: The patient's principal procedure is defined as one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure. Procedures shall be coded according to the ICD-9-CM. If only non-therapeutic procedures were performed, then a non-therapeutic procedure should be reported as the principal procedure, if it was a significant procedure. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for MS-DRG assignment. The date the principal procedure was performed shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

(b) For discharges occurring on and after October 1, ~~2014~~2015: The patient's principal procedure is defined as one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure. Procedures shall be coded according to the ICD-10-PCS. If only non-therapeutic procedures were performed, then a non-therapeutic procedure should be reported as the principal procedure, if it was a significant procedure. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for MS-DRG assignment. The date the principal procedure was performed shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97229. Definition of Data Element for Inpatients—Other Procedures and Dates.

(a) For discharges occurring up to and including September 30, ~~2014~~2015: All significant procedures are to be reported. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for MS-DRG assignment. Procedures shall be coded according to the ICD-9-CM. The dates shall be recorded with the corresponding other procedures and be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

(b) For discharges occurring on and after October 1, ~~2014~~2015: All significant procedures are to be reported. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for MS-DRG assignment. Procedures shall be coded according to the ICD-10-PCS. The dates shall be recorded with the corresponding other procedures and be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the 4-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97231. Definition of Data Element for Inpatients - Disposition of Patient.

(1) Effective with discharges on or after January 1, 1997 up to and including December 31, 2014, the patient's disposition, defined as the consequent arrangement or event ending a patient's stay in the reporting facility, shall be reported as one of the following:

(a) Routine Discharge. A patient discharged from this hospital to return home or to another private residence. Patients scheduled for follow-up care at a physician's office or a clinic not licensed or certified as an ambulatory surgery facility shall be included. Excludes patients referred to a home health service.

(b) Acute Care Within This Hospital. A patient discharged to inpatient hospital care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit within this reporting hospital.

(c) Other Type of Hospital Care Within This Hospital. A patient discharged to inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit within this reporting hospital.

(d) Skilled Nursing/Intermediate Care Within This Hospital. A patient discharged to a Skilled Nursing/Intermediate Care Distinct Part within this reporting hospital.

(e) Acute Care at Another Hospital. A patient discharged to another hospital to receive inpatient care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, coronary care, respiratory care, newborn intensive care, or burn unit of another hospital.

(f) Other Type of Hospital Care at Another Hospital. A patient discharged to another hospital to receive inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit of another hospital.

(g) Skilled Nursing/Intermediate Care Elsewhere. A patient discharged from this hospital to a Skilled Nursing/Intermediate Care type of care, either freestanding or a distinct part within another hospital, or to a Congregate Living Health Facility.

(h) Residential Care Facility. A patient discharged to a facility that provides special assistance to its residents in activities of daily living, but that provides no organized health care.

(i) Prison/Jail. A patient discharged to a correctional institution.

(j) Against Medical Advice. Patient left the hospital against medical advice without a physician's discharge order. Psychiatric patients discharged from away without leave (AWOL) status are included in this category.

(k) Died. All episodes of inpatient care that terminated in death. Patient expired after admission and before leaving the hospital.

(l) Home Health Service. A patient referred to a licensed home health service program.

(m) Other. A disposition other than mentioned above. Includes patients discharged to an inpatient hospice facility.

(2) Effective with discharges on or after January 1, 2015, the patient's disposition, defined as the consequent arrangement or event ending a patient's stay in the reporting facility, shall be reported using the code for one of the following:

Code	Patient Disposition
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care
04	Discharged/transferred to a facility that provides custodial or supportive care (includes Intermediate Care Facility)
05	Discharged/transferred to a designated cancer center or children's hospital
06	Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care
07	Left against medical advice or discontinued care
20	Expired
21	Discharged/transferred to court/law enforcement
43	Discharged/transferred to a federal health care facility
50	Hospice - Home
51	Hospice - Medical facility (certified) providing hospice level of care
61	Discharged/transferred to a hospital-based Medicare approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64	Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a Critical Access Hospital (CAH)
69	Discharged/transferred to a designated Disaster Alternative Care Site
70	Discharged/transferred to another type of health care institution not defined elsewhere in this code list
81	Discharged to home or self care with a planned acute care hospital inpatient readmission
82	Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission
83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission
84	Discharged/transferred to a facility that provides custodial or supportive care (includes Intermediate Care Facility) with a planned acute care hospital inpatient readmission
85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission

87 Discharged/Transferred to court/law enforcement with a planned acute care hospital inpatient readmission
88 Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
89 Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission
90 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission
91 Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission
92 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal) but not certified under Medicare with a planned acute care hospital inpatient readmission
93 Discharged/transferred to a psychiatric hospital or a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
94 Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission
95 Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission
00 Other

Note: Authority cited: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97244. Method of Submission.

(a) Reporting facilities shall use the MIRCal system for submitting reports. Data shall be reported utilizing a Microsoft Internet Explorer web browser that supports a secure Internet connection utilizing the Secure Hypertext Transfer Protocol (HTTPS or https) and 128-bit cypher strength Secure Socket Layer (SSL) through either:

(1) Online transmission of data reports as electronic data files, or

(2) Online entry of individual records.

~~(b)(1) For Hospital Discharge Abstract Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report discharges occurring on or after January 1, 2009 up to and including June 30, 2014, by diskette or compact disk provided the hospital complies with the Office's Format and File Specifications for MIRCal Online Transmission: Inpatient Data, as revised on March 20, 2008.~~

~~(2) For Hospital Discharge Abstract Data Reports: If an approved exemption~~

~~is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report discharges occurring on or after July 1, 2014 by diskette or compact disk provided the hospital complies with the Office's Format and File Specifications for MIRCal Online Transmission: Inpatient Data, as revised on January 1, 2014. This document specifies instructions for discharges occurring July 1, 2014 to September 30, 2014 and specifies separate instructions for discharges occurring on and after October 1, 2014.~~

~~(c)(1) For Emergency Care Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report encounters on or after January 1, 2009 up to and including September 30, 2014 by diskette or compact disk provided the hospital complies with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Department and Ambulatory Surgery, revised March 20, 2008.~~

~~(2) For Emergency Care Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report discharges occurring on or after October 1, 2014 by diskette or compact disk provided the hospital complies with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Department and Ambulatory Surgery, as revised on January 1, 2014.~~

~~(d)(1) For Ambulatory Surgery Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report encounters on or after January 1, 2009 up to and including September 30, 2014 by diskette or compact disk provided the hospital or freestanding ambulatory surgery clinic complies with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Department and Ambulatory Surgery, revised March 20, 2008.~~

~~(2) For Ambulatory Surgery Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report discharges occurring on or after October 1, 2014 by diskette or compact disk provided the hospital complies with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Department and Ambulatory Surgery, as revised on January 1, 2014.~~

Note: Authority cited: Section 128755, Health and Safety Code. Reference: Sections 128735, 128736 and 128737, Health and Safety Code.

97247. Approval Criteria.

(a) The following requirements must be met for a report to be approved by the Office:

(1) Complete transmittal information must be submitted with each report.

(2) The facility identification number stated in the transmittal information must be consistent with the facility identification number on each of the records in the report.

(3) The report period stated in the transmittal information must be consistent with all of the records in the report.

(4) The number of records stated in the transmittal information must be consistent with the number of records contained in the report.

(5) All records required to be reported pursuant to 97213(a) must be reported.

(6) The data must be reported in compliance with the format specifications in Section 97215.

(7) For report periods beginning on or after January 1, 2015, all records must contain a valid Principal Diagnosis.

(8~~7~~) The data must be at, or below, the Error Tolerance Level specified in Section 97248.

(9~~8~~) The data must be consistent with the reporting facility's anticipated trends and comparisons, except as in (A) below:

(A) If data are correctly reported and yet fail to meet approval criteria due to inconsistency with the reporting facility's anticipated trends and comparisons, the reporting facility may submit to the Office, in writing, a detailed explanation of why the data are correct as reported. The Office may determine, upon review of a written explanation, that it will approve a report.

(10~~9~~) Each report must contain only one type of record as specified in Subsections (1), (2), and (3) of Subsection (a) of Section 97213.

(b) The Office shall approve or reject each report within 15 days of receiving it. The report shall be considered not filed as of the date that the facility is notified that the report is rejected. Notification of approval or rejection of any report submitted online shall not take more than 15 days unless there is a documented MIRCal system failure.

Note: Authority cited: Sections 128810 and 128755, Health and Safety Code. Reference: Sections 128735, 128736 and 128737, Health and Safety Code.

97248. Error Tolerance Level.

(a) The Error Tolerance Level (ETL) for data reported to the Office shall be no more than 2%. Errors as defined in Subsection (j) of Section 97212, must be corrected to the ETL.

(b)(1) For hospital discharge abstract data reports that do not exceed the Error Tolerance Level specified in Subsection (a) of this Section, defaults will be as shown in Table 1A for discharges reported on and after July 1, 2008 up to, and including, discharges occurring on ~~September 30, 2014~~December 31, 2014.

Table 1A. Hospital Discharge Abstract Data Record Defaults

Invalid Data Element	*Default*
Admission date	delete record
Principal Diagnosis	799.9
All other data elements	blank or zero

~~(2) For discharges occurring on and after October 1, 2014: For hospital discharge abstract data reports that do not exceed the Error Tolerance Level specified in Subsection (a) of this Section, defaults will be as shown in Table 1B.~~

~~Table 1B. Hospital Discharge Abstract Data Record Defaults~~

~~*Invalid Data Element*~~	~~*Default*~~
~~Admission date~~	~~delete record~~
~~Principal Diagnosis~~	~~R69~~
~~All other data elements~~	~~blank or zero~~

(2) For discharges occurring on and after January 1, 2015: For hospital discharge abstract data reports that do not exceed the Error Tolerance Level specified in Subsection (a) of this Section, defaults will be as shown in Table 1B.

Table 1B. Hospital Discharge Abstract Data Record Defaults

Invalid Data Element	*Default*
Admission date	delete record
All other data elements	blank or zero

(c)(1) For encounters occurring up to and including ~~September 30, 2014~~December 31, 2014: For emergency care data reports that do not exceed the Error Tolerance Level specified in Subsection (a) of this Section, defaults will be as shown in Table 2A.

Table 2A: Emergency Care Data Record Defaults

Invalid Data Element	*Default*

Service date	delete record
Principal Diagnosis	799.9
All other data elements	blank or zero

~~(2) For encounters occurring on and after October 1, 2014: For emergency care data reports that do not exceed the Error Tolerance Level specified in Subsection (a) of this Section, defaults will be as shown in Table 2B.~~

~~Table 2B: Emergency Care Data Record Defaults~~

~~*Invalid Data Element*~~	~~*Default*~~
~~Service date~~	~~delete record~~
~~Principal Diagnosis~~	~~R69~~
~~All other data elements~~	~~blank or zero~~

(2) For encounters occurring on and after January 1, 2015: For emergency care data reports that do not exceed the Error Tolerance Level specified in Subsection (a) of this Section, defaults will be as shown in Table 2B.

Table 2B: Emergency Care Data Record Defaults

Invalid Data Element	*Default*
Service date	delete record
All other data elements	blank or zero

(d)(1) For encounters occurring up to and including ~~September 30, 2014~~December 31, 2014: For ambulatory surgery data reports that do not exceed the Error Tolerance Level specified in Subsection (a) of this Section, defaults will be as shown in Table 3A.

Table 3A: Ambulatory Surgery Data Record Defaults

Invalid Data Element	*Default*
Service date	delete record
Principal Diagnosis	799.9
All other data elements	blank or zero

~~(2) For encounters reported on and after October 1, 2014: For ambulatory surgery data reports that do not exceed the Error Tolerance Level specified in Subsection (a) of this Section, defaults will be as shown in Table 3B.~~

~~Table 3B: Ambulatory Surgery Data Record Defaults~~

~~*Invalid Data Element*~~	~~*Default*~~
~~Service date~~	~~delete record~~

~~Principal Diagnosis~~ ~~R69~~
~~All other data elements~~ ~~blank or zero~~

(2) For encounters occurring on and after January 1, 2015: For ambulatory surgery data reports that do not exceed the Error Tolerance Level specified in Subsection (a) of this Section, defaults will be as shown in Table 3B.

Table 3B: Ambulatory Surgery Record Defaults

Invalid Data Element	*Default*
Service date	delete record
All other data elements	blank or zero

Note: Authority: Section 128755, Health and Safety Code.
Reference: Sections 128735, 128736, and 128737, Health and Safety Code.

97258. Definition of Data Element for ED and AS—Principal Diagnosis.

(a) For encounters occurring up to and including September 30, ~~2014~~2015: The patient's principal diagnosis, defined as the condition, problem, or other reason established to be the chief cause of the encounter for care, shall be coded according to the ICD-9-CM.

(b) For encounters occurring on and after October 1, ~~2014~~2015: The patient's principal diagnosis, defined as the condition, problem, or other reason established to be the chief cause of the encounter for care, shall be coded according to the ICD-10-CM.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97259. Definition of Data Element for ED and AS—Other Diagnoses.

(a) For encounters occurring up to and including September 30, ~~2014~~2015: The patient's other diagnoses are defined as all conditions that coexist at the time of the encounter for emergency or ambulatory surgery care, that develop subsequently during the encounter, or that affect the treatment received. Diagnoses shall be coded according to the ICD-9-CM. ICD-9-CM codes from the Supplementary Classification of External Causes of Injury and Poisoning (E800-E999) and codes from Morphology of Neoplasms (M800-M997 codes) shall not be reported as other diagnoses.

(b) For encounters occurring on and after October 1, ~~2014~~2015: The patient's other diagnoses are defined as all conditions that coexist at the time of the encounter for emergency or ambulatory surgery care, that develop subsequently during the encounter, or that affect the treatment received. Diagnoses shall be coded according to

the ICD-10-CM. ICD-10-CM codes from External Causes of Morbidity (V00-Y99) shall not be reported as other diagnoses.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97260. Definition of Data Element for ED and AS—External Causes of Morbidity.

(a) For encounters occurring up to and including September 30, ~~2014~~2015: The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported on records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an E-code is applicable. An E-code is to be reported on the record for the first episode of care reportable to the Office during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. If the E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the encounter record. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect.

(b) For encounters occurring on and after October 1, ~~2014~~2015: The external causes of morbidity shall be coded according to the ICD-10-CM External Causes of Morbidity (V00-Y99). The external cause of morbidity that resulted in the injury or health condition shall be listed first. Additional cause of morbidity codes shall be reported if necessary to describe the mechanisms that contributed to, or the causal events surrounding, the injury or health condition.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97261. Definition of Data Element for ED and AS—Other External Cause of Injury.

(a) For encounters occurring up to and including September 30, ~~2014~~2015: The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for records with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code

is applicable. An E-code is to be reported on the record for the first episode of care reportable to the Office during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. If the E-code has been previously reported on a discharge or encounter record to the Office, the E-code should not be reported again on the encounter record. If the principal E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an E-code shall be reported to designate the place of occurrence, if available in the medical record. Additional E-codes shall be reported, if necessary to completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect.

Note: Authority: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.

97264. Definition of Data Element for ED and AS - Disposition of Patient.

(1) The patient's disposition, defined as the consequent arrangement or event ending a patient's encounter in the reporting facility, shall be reported as one of the following for encounters on or before December 31, 2014:

(a) Discharged to home or self care (routine discharge).

(b) Discharged/Transferred to a short-term general hospital for inpatient care

(c) Discharged/Transferred to a skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care.

(d) Discharged/Transferred to a facility that provides custodial or supportive care (includes intermediate care facility).

(e) Discharged/Transferred to a Designated Cancer Center or Children's Hospital.

(f) Discharged/Transferred to home under care of an organized home health service organization in anticipation of covered skilled care.

(g) Left against medical advice or discontinued care.

(h) Expired.

(i) Discharged/Transferred to Court/Law Enforcement.

(j) Discharged/Transferred to a Federal health care facility.

(k) Discharged home with hospice care.

(l) Discharged to a medical facility with hospice care.

(m) Discharged/Transferred to a hospital-based Medicare approved swing bed.

(n) Discharged/Transferred to an inpatient rehabilitation facility (IRF) including a rehabilitation distinct part unit of a hospital.

(o) Discharged/Transferred to a Medicare certified long term care hospital (LTCH).

(p) Discharged/Transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare.

(q) Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.

(r) Discharged/Transferred to a Critical Access Hospital (CAH).

(s) Discharged/Transferred to another type of health care institution not defined elsewhere in this code list.

(t) Other.

(2) The patient's disposition, defined as the consequent arrangement or event ending a patient's encounter in the reporting facility, shall be reported as one of the following for encounters on or after January 1, 2015:

Code	Patient Disposition
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to a short term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care
04	Discharged/transferred to a facility that provides custodial or supportive care (includes Intermediate Care Facility)
05	Discharged/transferred to a designated cancer center or children’s hospital
06	Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care
07	Left against medical advice or discontinued care
20	Expired
21	Discharged/transferred to court/law enforcement
43	Discharged/transferred to a federal health care facility
50	Hospice - Home
51	Hospice - Medical facility (certified) providing hospice level of care

61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
69 Discharged/transferred to a designated Disaster Alternative Care Site
70 Discharged/transferred to another type of health care institution not defined elsewhere in this code list
81 Discharged to home or self care with a planned acute care hospital inpatient readmission
82 Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission
83 Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission
84 Discharged/transferred to a facility that provides custodial or supportive care (includes Intermediate Care Facility) with a planned acute care hospital inpatient readmission
85 Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
86 Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission
87 Discharged/Transferred to court/law enforcement with a planned acute care hospital inpatient readmission
88 Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
89 Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission
90 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission
91 Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission
92 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal) but not certified under Medicare with a planned acute care hospital inpatient readmission
93 Discharged/transferred to a psychiatric hospital or a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
94 Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission
95 Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission

00 Other

Note: Authority cited: Section 128810, Health and Safety Code.
Reference: Sections 128736 and 128737, Health and Safety Code.