

CALIFORNIA CODE OF REGULATIONS

TITLE 22

DIVISION 7

CHAPTER 10  
HEALTH FACILITY DATA

ARTICLE 8  
PATIENT DATA REPORTING REQUIREMENTS

45 Day Notice Text added and ~~deleted~~  
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## ARTICLE 8: PATIENT DATA REPORTING REQUIREMENTS

### 97215. Format.

(a) Hospital Discharge Abstract Data reports for discharges occurring on or after January 1, 2005, up to and including June 30, 2008, shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Patient Discharge Data, dated April 2004, and hereby incorporated by reference. Hospital Discharge Abstract Data reports for discharges occurring on or after July 1, 2008 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.

(b) Emergency Care Data reports for encounters occurring on or after January 1, 2005~~7~~, up to and including December 31, 2008, shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Care Data, dated ~~April 2004~~ January 2006, and hereby incorporated by reference. Emergency Care Data reports for encounters occurring on or after January 1, 2009 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.

(c) Ambulatory Surgery Data reports for encounters occurring on or after January 1, 2005~~7~~, up to and including December 31, 2008, shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Care and Ambulatory Surgery Data, dated ~~April 2004~~ January 2006. Ambulatory Surgery Data reports for encounters occurring on or after January 1, 2009 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.

(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: 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 ~~Whether the Condition was Present at Admission~~ Present on Admission Indicator.**

(a) 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.

(b) Effective with discharges on or after January 1, 1996, and until and including June 30, 2008, whether the patient's principal diagnosis was present at admission shall be reported as one of the following:

- (1) Yes.
- (2) No.
- (3) Uncertain.

(c) 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 on admission.
- (4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present on admission or not.
- (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 Whether the Condition was Present at Admission Present on Admission Indicator.**

(a) 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.

(b) Effective with discharges on or after January 1, 1996, and until and including June 30, 2008, whether the patient's other diagnosis was present at admission shall be reported as one of the following:

- (1) Yes.
- (2) No.
- (3) Uncertain.

(c) 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 on admission.
- (4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present on admission or not.
- (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 Cause of Injury and Present on Admission Indicator.**

(a) 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, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. 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.

(b) Effective with 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 on admission.
- (4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present on admission or not.
- (5)(blank) Exempt from present on admission reporting.

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

**97234. Definition of Data Element for Inpatients—Principal Language Spoken.**

Effective with discharges occurring on or after January 1, 2009, the patient's principal language spoken shall be reported using one of the following three alternatives:

(a) If the patient's principal language spoken is known and is included in the following list of alternatives, report the three letter code from the list:

- (1) ENG – English
- (2) ARA – Arabic
- (3) ARM – Armenian

- (4) CHI – Chinese
- (5) FRE – French
- (6) CPF – French Creole
- (7) GER – German
- (8) GRE – Greek
- (9) GUJ – Gujarathi
- (10) HEB – Hebrew
- (11) HIN – Hindi
- (12) HUN – Hungarian
- (13) ITA – Italian
- (14) JPN – Japanese
- (15) KOR – Korean
- (16) LAO – Laotian
- (17) HMN – Miao, Hmong
- (18) KHM – Mon-Khmer, Cambodian
- (19) NAV – Navajo
- (20) PER – Persian
- (21) POL – Polish
- (22) POR – Portuguese
- (23) RUS – Russian
- (24) SCR – Serbo-Croatian
- (25) SPA – Spanish
- (26) TGL – Tagalog
- (27) THA – Thai
- (28) URD – Urdu
- (29) VIE – Vietnamese
- (30) YID – Yiddish

(b) Other. If the principal language spoken is known, but is not listed in subsection (a), report the full name of the language.

(c) If the principal language spoken is unknown, report the three digit code 999.

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

Reference: Section 128735, Health and Safety Code.

#### **97241. Extensions of Time to File Reports.**

(a) Extensions are available to reporting facilities that are unable to complete their submission of reports by the due date prescribed in Section 97211.

(1) Requests for extension shall be filed on or before the required due date of the report by using the extension request screen available through the MIRCal system or by using the Patient Data Reporting Extension Request (form DD1805) as revised ~~06/09/2005~~ June 9, 2005. Notices regarding the use of extension days, and new due dates, as well as notices of approval and rejection, will be e-mailed to the primary contact and Administrator e-mail addresses provided by the facility. If a Designated Agent e-mail contact address has been provided by the

facility, this contact will also be notified. ~~These notices will also be available to all facility MIRCal users on the MIRCal Submission Status page.~~

(2) The Office shall respond within 5 days of receipt of the request by either granting what is determined to be a reasonable extension or disapproving the request. The Office shall not grant extensions that exceed the maximum number of days available for the report period for all extensions. If a reporting facility submits the report prior to the due date of an extension, those days not used will be applied to the number of remaining extension days. A reporting facility that wishes to contest any decision of the Office shall have the right to appeal, pursuant to Section 97052.

(b) A maximum of 14 extension days will be allowed for all extensions and resubmittals of reports with discharges or encounters occurring on or after January 1, 2005.

(c) If a report is rejected on, or within 7 days before, or at any time after, any due date established by Subsections (c), or (d), of Section 97211, the Office shall grant, if available, an extension of 7 days. If less than 7 days are available all available extension days will be granted.

(d) If the Office determines that the MIRCal system was unavailable for data submission for one or more periods of 4 or more continuous supported hours during the 4 State working days before a due date established pursuant to Section 97211, the Office shall extend the due date by 7 days.

Note: Authority: Section 128810, Health and Safety Code.  
Reference: Section 128770, 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) 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, 2005 through June 30, 2008 by diskette, compact disk or Hospital Discharge Abstract Data Record Manual Abstract Reporting Form, provided the hospital complies with the Office's Format and File Specifications for MIRCal Online Transmission; Patient Discharge Data as revised in April 2004. The version of the Manual Abstract Reporting Form

(OSHPD 1370.IP) to be used is as revised on ~~03/17/2004~~ March 17, 2004 and hereby incorporated by reference. Copies of Form 1370.IP shall be made by the hospital to submit its discharge data and each additional copy shall be made on one sheet, front (Page 1 of 2) and back (Page 2 of 2).

(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 (including Present on Admission Indicator) occurring on or after July 1, 2008 up to and including December 31, 2008 by diskette, compact disk or Hospital Inpatient Data Record Manual Abstract Reporting Form, provided the hospital complies with the Office's Format and File Specifications for MIRCal Online Transmission: Inpatient Data, as revised on March 20, 2008. The version of the Manual Abstract Reporting Form (OSHPD 1370.IP) to be used is as revised on January 18, 2008 and hereby incorporated by reference. Copies of Form 1370.IP shall be made by the hospital to submit its discharge data and each additional copy shall be made on one sheet, front (Page 1 of 2) and back (Page 2 of 2).

(2) If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report discharges (including Principal Language Spoken) occurring on or after January 1, 2009, by diskette, compact disk or Hospital Inpatient Data Record Manual Abstract Reporting Form, provided the hospital complies with the Office's Format and File Specifications for MIRCal Online Transmission: Inpatient Data, as revised on March 20, 2008. The version of the Manual Abstract Reporting Form (OSHPD 1370.IP) to be used is as revised on February 26, 2008 and hereby incorporated by reference. Copies of Form 1370.IP shall be made by the hospital to submit its discharge data and each additional copy shall be made on one sheet, front (Page 1 of 2) and back (Page 2 of 2).

(c) 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 ~~October 1, 2004~~ January 1, 2007 up to and including encounters on December 31, 2008 by diskette, compact disk or Emergency Care Data Record Manual Abstract Reporting Form (OSHPD 1370.ED), provided the hospital complies with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Department and Ambulatory Surgery, dated revised January 2006. The version of the Manual Abstract Reporting Form (1370.ED) to be used is dated ~~01/01/2006~~ January 1, 2006 and hereby incorporated by reference. Copies of Form 1370.ED shall be made by the hospital to submit its encounter data and each additional copy shall be made on three sheets (Page 1 of 3), (Page 2 of 3), and (Page 3 of 3).

(1) 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 by diskette, compact disk or Emergency Care Data Record Manual Abstract Reporting Form (OSHPD 1370.ED), 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. The version of the Manual Abstract Reporting Form (1370.ED) to be used is as revised on February 26, 2008 and hereby incorporated by reference. Copies of Form 1370.ED shall be made by the hospital to submit its encounter data and each additional copy shall be made on three sheets (Page 1 of 3), (Page 2 of 3), and (Page 3 of 3).

(d) 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 or freestanding ambulatory surgery clinic may report encounters on or after ~~October 1, 2004~~ January 1, 2007 up to and including encounters on December 31, 2008 by diskette, compact disk or Ambulatory Surgery Data Record Manual Abstract Reporting Form (OSHPD 1370.AS), provided the reporting facility complies with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Department and Ambulatory Surgery, dated January 2006. The version of the Manual Abstract Reporting Form (1370.AS) to be used is ~~dated 01/01/2006~~ as revised January 1, 2006 and hereby incorporated by reference. Copies of Form 1370.AS shall be made by the hospital or freestanding ambulatory surgery clinic to submit its encounter data and each additional copy shall be made on three sheets (Page 1 of 3), (Page 2 of 3), and (Page 3 of 3).

(1) 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 by diskette, compact disk or Ambulatory Surgery Data Record Manual Abstract Reporting Form (OSHPD 1370.AS), 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. The version of the Manual Abstract Reporting Form (1370.AS) to be used is as revised on February 26, 2008 and hereby incorporated by reference. Copies of Form 1370.AS shall be made by the hospital to submit its encounter data and each additional copy shall be made on three sheets (Page 1 of 3), (Page 2 of 3), and (Page 3 of 3).

Note: Authority: Section 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 (k) of Section 97212, must be corrected to the ETL.

(b) 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 data collected on or before June 30, 2008.

<b>Table 1A Hospital Discharge Abstract Data Record Defaults</b>	
<b>Invalid Data Element</b>	<b>Default</b>

Admission date	delete record
Discharge date	delete record
Principal Diagnosis	799.9
Condition Present at Admission for Principal Diagnosis	Yes
All other data elements	blank or zero

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 for discharges reported on and after July 1, 2008.

<b>Table 1B Hospital Discharge Abstract Data Record Defaults</b>	
<b>Invalid Data Element</b>	<b>Default</b>
Admission date	delete record
Principal Diagnosis	799.9
All other data elements	blank or zero

(c) 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 2.

<b>Table 2: Emergency Care Data Record Defaults</b>	
<b>Invalid Data Element</b>	<b>Default</b>
Service date	delete record
Principal Diagnosis	799.9
All other data elements	blank or zero

(d) 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 3.

<b>Table 3: Ambulatory Surgery Data Record Defaults</b>	
<b>Invalid Data Element</b>	<b>Default</b>
Service date	delete record
Principal Diagnosis	799.9
All other data elements	blank or zero

Authority: Section 128755, Health and Safety Code.

Reference: Sections 128735, 128736, and 128737, Health and Safety Code.

**97267. Definition of Data Element for ED and AS—Principal Language Spoken.**

Effective with encounters occurring on or after January 1, 2009, the patient's principal language spoken shall be reported using one of the following three alternatives:

(a) If the patient's principal language spoken is known and is included in the following list of alternatives, report the three letter code from the list:

- (1) ENG – English
- (2) ARA – Arabic
- (3) ARM – Armenian
- (4) CHI – Chinese
- (5) FRE – French
- (6) CPF – French Creole
- (7) GER – German
- (8) GRE – Greek
- (9) GUJ – Gujarathi
- (10) HEB – Hebrew
- (11) HIN – Hindi
- (12) HUN – Hungarian
- (13) ITA – Italian
- (14) JPN – Japanese
- (15) KOR – Korean
- (16) LAO – Laotian
- (17) HMN – Miao, Hmong
- (18) KHM – Mon-Khmer, Cambodian
- (19) NAV – Navajo
- (20) PER – Persian
- (21) POL – Polish
- (22) POR – Portuguese
- (23) RUS – Russian
- (24) SCR – Serbo-Croatian
- (25) SPA – Spanish
- (26) TGL – Tagalog
- (27) THA – Thai
- (28) URD – Urdu
- (29) VIE – Vietnamese
- (30) YID – Yiddish

(b) Other. If the principal language spoken is known, but is not listed in subsection (a), report the full name of the language.

(c) If the principal language spoken is unknown, report the three digit code 999.

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

Reference: Sections 128736 and 128737, Health and Safety Code.