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

CALIFORNIA CODE OF REGULATIONS

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

Sections 97240, 97241 and 97246.

97240. Request for Modifications to Patient Data Reporting.

(a) Reporting facilities may file a request with the Office for modifications to Hospital Discharge Abstract Data, Emergency Care Data, or Ambulatory Surgery Data reporting requirements. The modification request shall be supported by a detailed justification of the hardship that full reporting of data would have on the reporting facility; an explanation of attempts to meet data reporting requirements; and a description of any other factors that might justify a modification. Modifications may be approved for no more than one year. Modifications to the data reporting requirements must be approved before data to which they apply will be accepted. Any modifications to reporting requirements are subject to disclosure to data users.

(b) In determining whether a modification to data reporting requirements will be approved, the Office shall consider the information provided pursuant to subsection (a) and evaluate whether the requested modifications would impair the Office's ability to process the data or interfere with the purposes of the data reporting programs under the Act.

(c) Reporting facilities that did not have any discharges or encounters that are required to be reported pursuant to Section 97213(a) for a specific report period must complete and submit a separate No Data to Report form (OSH-HID 772) as Revised ~~January 2011~~August 2014 on or before the required due date of the report either by using the online screen available through the MIRCal system or by printing the online No Data to Report form and mailing or faxing it to the Office for that report period.

(d) Any facility that is not licensed to provide inpatient care, or does not provide Emergency Care encounters, or does not provide outpatient procedures, or is not licensed as a surgical clinic, and from whom such reporting is not therefore expected, is not required to file a No Data to Report form.

Note: Authority cited: Sections 128760 and 128810, Health and Safety Code. Reference: Sections 128735, 128736, 128737 and 128760, Health and Safety Code.

97241. Extensions of Time to File Reports.

(a) Extensions are available to reporting facilities that are unable to complete the 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 OSH-HID 770) as revised ~~January 2011~~August 2014. 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.

(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 cited: Section 128810, Health and Safety Code. Reference: Section 128770, Health and Safety Code.

97246. Data Transmittal Requirements.

(a) Reporting facilities submitting their own data online must use the MIRCal Online Data Transmittal by Facility method to file or submit each report. The following information must be included: the facility name, the unique identification number specified in Section 97210, the beginning and ending dates of the report period, the number of records in the report and the following statement of certification:
I certify under penalty of perjury that I am an official of this facility and am duly authorized to submit these data; and that, to the extent of my knowledge and information, the accompanying records are true and correct, and that the applicable definitions of the data elements as set forth in Article 8 (Patient Data Reporting Requirements) of Chapter 10 (Health Facility Data) of Division 7 of Title 22 of in the California Code of Regulations, have been followed by this facility.

(b) Reporting facilities that choose to designate an agent to submit their records must submit a hardcopy Agent Designation Form (OSH-HID 771, Revised: ~~January 2011~~August 2014), hereby incorporated by reference, to the Office's Patient Data Program. Receipt of a subsequent hardcopy Agent Designation Form supercedes the previous designation. Each reporting facility shall notify the Office's Patient Data Program within 15 days after any change in designated agent.

(c) An agent who has been designated by a reporting facility to submit that facility's data online must use the MIRCal Online Data Transmittal by Agent method to file or submit reports. The following information must be included: the facility name, the facility identification number specified in Section 97210, the beginning and ending dates of the report period, and the number of records in the report.

(d) Reporting facilities with an approved exemption to submit records using a diskette, or a compact disk must submit a hardcopy Individual Facility Transmittal Form (OSHPD 1370.1, Revised: March 10, 2009), hereby incorporated by reference. The Individual Facility Transmittal Form shall accompany the report.

(e) Agents who have been designated by a reporting facility to submit a facility's report in accordance with an approved exemption as described in (d) above must submit a hardcopy Designated Agent Transmittal Form (OSHPD 1370.2, Revised: 06/09/2005), hereby incorporated by reference. The Designated Agent Transmittal Form shall accompany the facility's report.

(f) A facility's administrator may designate no more than 3 User Account Administrators. For each User Account Administrator there must be an original signed Facility User Account Administrator Agreement Form (OSH-HID 773, Revised: February 2011), and hereby incorporated by reference, submitted to the Office.

(g) A signed Designated Agent User Agreement Form (OSH-HID 774, Revised: February 2011), hereby incorporated by reference, must be submitted to the Office by an agent who has been designated to submit data online.

(h) Reporting facilities and designated agents may obtain copies of the forms from the OSHPD web site at www.oshpd.ca.gov or by contacting the Office's Patient Data Program at (916) 326-3920 or (916) 326-3935.

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

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State of California – Health and Human Services Agency

Office of Statewide Health Planning and Development
Healthcare Information Division
Patient Data Section
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Sacramento, California 95811-6213
(916) 326-3935; Fax (916) 322-9555
www.oshpd.ca.gov/HID/MIRCal/

REPEAL

No Data to Report

1. Facility Name: _____

2. Facility ID Number: | | | | | | |

3. We do not have data to report for the above mentioned facility for the following reason(s):

a) **Hospital Inpatient Care:**
Report Period: From _____ **to** _____
☐ We are not licensed to provide inpatient care effective: _____
☐ We are licensed for inpatient care for this report period, but did not have any discharges as defined in Section 97213(a) (1) of the California Code of Regulations.

b) **Emergency Department:**
Report Period: From _____ **to** _____
☐ We are not licensed to provide emergency department care effective: _____
☐ We are licensed for emergency department services for this report period, but did not have any encounters as defined in Section 97213(a) (2) of the California Code of Regulations.

c) **Hospital-Based Ambulatory Surgery:**
Report Period: From _____ **to** _____
☐ We did not perform procedures on an outpatient basis in a general operating room, ambulatory surgery room, endoscopy unit or cardiac catheterization laboratory as defined in Section 97213(a) (3) of the California Code of Regulations.

d) **Freestanding Ambulatory Surgery Clinic:**
Report Period: From _____ **to** _____
☐ We are not licensed by the State of California as a surgical clinic effective: _____
☐ We are licensed as a surgical clinic, but did not perform ambulatory surgery procedures for this report period, as defined in Section 97213(a) (3) of the California Code of Regulations.

4. Additional Explanation: _____

_____

_____

5. Submitted by:

Print Name	Title/Position
Signature	Date
Telephone	E-mail

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REPEAL

PATIENT DATA REPORTING EXTENSION REQUEST

Fax Request to: (916) 322-9555
Or (916) 327-1262
Attn: Patient Data Section

Date: _____

1. Facility Name: _____
2. Facility Identification Number: _____
3. Address: _____
4. Data Type:

   - ☐ Inpatient
   - ☐ Emergency Department
   - ☐ Ambulatory Surgery

5. Report Period Begin Date: _____
6. Report Period End Date: _____
7. Designated Agent (if applicable): _____
8. Number of Extension Days Requested: _____
9. Person Requesting Extension (print): _____
10. Signature: _____
11. Title: _____
12. Phone: _____ E-mail: _____

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REPEAL

Agent Designation Form

In order to designate a third party agent to submit data on your behalf, your facility must complete this form. All information must be provided, including a signature from a facility administrator or primary contact.

Please print clearly

Section 1: Facility Information *(all information is required)*

1. FACILITY ID NUMBER:	2. FACILITY NAME:
3. DATA TYPE(S): ☐ Inpatient ☐ Emergency Department ☐ Ambulatory Surgery Check one or more Data Type(s). *If none are checked, the Agent will be given access to all Data Types associated with your facility.*	
4. FACILITY BUSINESS ADDRESS (MAILING ADDRESS):	
5. FACILITY CONTACT NAME:	6. TITLE:
7. PHONE:	8. E-MAIL ADDRESS:

Section 2: Designated Agent Information *(all information is required)*

9. NAME OF DESIGNATED AGENT (COMPANY NAME):	
10. BUSINESS ADDRESS (MAILING ADDRESS):	
11. CONTACT NAME:	
12. PHONE:	13. E-MAIL ADDRESS:
DESIGNATION EFFECTIVE DATE	
14. EFFECTIVE REPORT PERIOD BEGIN DATE:	Designation is effective until OSHPD receives written notification of revocation or new designation.

By signing this document, I certify that I am an official of my facility and I am approving the aforementioned Designated Agent to submit data on behalf of my facility for the designated data type(s) and effective date.

15. NAME (PRINT):	16. TITLE:
17. SIGNATURE:	18. DATE:

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No Data to Report

1. Facility Name: _____

2. Facility ID Number: | | | | | | |

3. We do not have data to report for the above mentioned facility for the following reason(s):

a) **Hospital Inpatient Care:**
Report Period: From _____ **to** _____
☐ We are not licensed to provide inpatient care effective: _____

☐ We are licensed for inpatient care for this report period, but did not have any discharges as defined in Section 97213(a) (1) of the California Code of Regulations.

b) **Emergency Department:**
Report Period: From _____ **to** _____
☐ We are not licensed to provide emergency department care effective: _____

☐ We are licensed for emergency department services for this report period, but did not have any encounters as defined in Section 97213(a) (2) of the California Code of Regulations.

c) **Hospital-Based Ambulatory Surgery:**
Report Period: From _____ **to** _____
☐ We did not perform procedures on an outpatient basis in a general operating room, ambulatory surgery room, endoscopy unit or cardiac catheterization laboratory as defined in Section 97213(a) (3) of the California Code of Regulations.

d) **Freestanding Ambulatory Surgery Clinic:**
Report Period: From _____ **to** _____
☐ We are not licensed by the State of California as a surgical clinic effective: _____

☐ We are licensed as a surgical clinic, but did not perform ambulatory surgery procedures for this report period, as defined in Section 97213(a) (3) of the California Code of Regulations.

4. Additional Explanation: _____

_____

_____

5. Submitted by:

_____ Print Name	_____ Title/Position
_____ Signature	_____ Date
_____ Telephone	_____ E-mail

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Fax Request to: (916) 322-9555
Or (916) 327-1262
Attn: Patient Data Section

Date: _____

1. Facility Name: _____
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3. Address: _____
4. Data Type:
   - ☐ Inpatient
   - ☐ Emergency Department
   - ☐ Ambulatory Surgery
5. Report Period Begin Date: _____
6. Report Period End Date: _____
7. Designated Agent (if applicable): _____
8. Number of Extension Days Requested: _____
9. Person Requesting Extension (print): _____
10. Signature: _____
11. Title: _____
12. Phone: _____ E-mail: _____

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1. FACILITY ID NUMBER:	2. FACILITY NAME:
3. DATA TYPE(S): ☐ Inpatient ☐ Emergency Department ☐ Ambulatory Surgery Check one or more Data Type(s). *If none are checked, the Agent will be given access to all Data Types associated with your facility.*	
4. FACILITY BUSINESS ADDRESS (MAILING ADDRESS):	
5. FACILITY CONTACT NAME:	6. TITLE:
7. PHONE:	8. E-MAIL ADDRESS:

Section 2: Designated Agent Information *(all information is required)*

9. NAME OF DESIGNATED AGENT (COMPANY NAME):	
10. BUSINESS ADDRESS (MAILING ADDRESS):	
11. CONTACT NAME:	
12. PHONE:	13. E-MAIL ADDRESS:
DESIGNATION EFFECTIVE DATE	
14. EFFECTIVE REPORT PERIOD BEGIN DATE:	Designation is effective until OSHPD receives written notification of revocation or new designation.

By signing this document, I certify that I am an official of my facility and I am approving the aforementioned Designated Agent to submit data on behalf of my facility for the designated data type(s) and effective date.

15. NAME (PRINT):	16. TITLE:
17. SIGNATURE:	18. DATE: