

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS Z-	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER 2014-0310-01N	EMERGENCY NUMBER
For use by Office of Administrative Law (OAL) only			
NOTICE		REGULATIONS	
AGENCY WITH RULEMAKING AUTHORITY Office of Statewide Health Planning and Development			AGENCY FILE NUMBER (if any)

ENDORSED FILED
IN THE OFFICE OF

2014 MAR 25 PM 2:31

Debra Bowen
DEBRA BOWEN
SECRETARY OF STATE

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 <input type="checkbox"/> Notice re Proposed Regulatory Action <input type="checkbox"/> Other	4 AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
OAL USE ONLY <input type="checkbox"/> Approved as Submitted <input type="checkbox"/> Approved as Modified <input type="checkbox"/> Disapproved/Withdrawn	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a SUBJECT OF REGULATION(S) Patient Data Reporting Requirements: Present on Admission Indicators	1b ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S) None
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 N/A
	AMEND 97225, 97226, 97227
TITLE(S) 22	REPEAL N/A
3. TYPE OF FILING	
<input type="checkbox"/> Regular Rulemaking (Gov. Code §11346)	<input type="checkbox"/> 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.
<input type="checkbox"/> Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)	<input type="checkbox"/> Emergency Readopt (Gov. Code, §11346.1(h))
<input type="checkbox"/> Emergency (Gov. Code, §11346.1(b))	<input type="checkbox"/> Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
<input type="checkbox"/> File & Print	<input checked="" type="checkbox"/> Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> 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)	
<input type="checkbox"/> Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))	<input type="checkbox"/> Effective on filing with Secretary of State
<input checked="" type="checkbox"/> \$100 Changes Without Regulatory Effect	<input type="checkbox"/> Effective other (Specify)
6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY	
<input type="checkbox"/> Department of Finance (Form STD. 399) (SAM §6660)	<input type="checkbox"/> Fair Political Practices Commission
<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> State Fire Marshal
7 CONTACT PERSON Irene Ogonna	TELEPHONE NUMBER (916) 326-3937
FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional) irene.ogbonna@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 <i>Ron Spingarn</i>	DATE 3/10/14
TYPED NAME AND TITLE OF SIGNATORY Ron Spingarn, Deputy Director, Healthcare Information Division	

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

MAR 25 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: 97225, 97226, 97227

Repeal sections:

NOTICE OF APPROVAL OF CHANGES
WITHOUT REGULATORY EFFECT

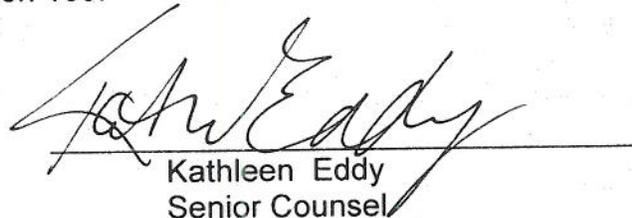
California Code of Regulations, Title 1,
Section 100

OAL File No. 2014-0310-01 N

This file without regulatory effect conforms the description of "present on admission" conditions with the current national standard.

OAL approves this change without regulatory effect as meeting the requirements of California Code of Regulations, Title 1, section 100.

Date: 3/25/2014


Kathleen Eddy
Senior Counsel

For: DEBRA M. CORNEZ
Director

Original: Robert David
Copy: Irene Ogbonna

TEXT

CALIFORNIA CODE OF REGULATIONS
TITLE 22, DIVISION 7, CHAPTER 10, HEALTH FACILITY DATA
ARTICLE 8: PATIENT DATA REPORTING REQUIREMENTS
Sections 97225, 97226, 97227.

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: 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: 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 ~~or~~ at the time of inpatient admission.
- (4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present ~~or~~ at the time of inpatient 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 Present on Admission Indicator.

(a)(1) For discharges occurring up to and including September 30, 2014: 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: 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 ~~on~~ at the time of inpatient admission.
- (4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present ~~on~~ at the time of inpatient 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 Causes of Morbidity and Present on Admission Indicator.

(a)(1) For discharges up to and including September 30, 2014: 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: 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 ~~on~~ at the time of inpatient admission.
- (4) W. Clinically undetermined. Provider is unable to clinically determine whether the condition was present ~~on~~ at the time of inpatient 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.