

NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER Z-	REGULATORY ACTION NUMBER 2014-1014-03N	EMERGENCY NUMBER
For use by Office of Administrative Law (OAL) only			
NOTICE		REGULATIONS	

ENDORSED FILED
IN THE OFFICE OF

2014 NOV 18 PM 1:55


 DEBRA BOWEN
 SECRETARY OF STATE

 2014 OCT 14 PM 2:04
 OFFICE OF
 ADMINISTRATIVE LAW

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 Disapproved/Withdrawn	NOTICE REGISTER NUMBER	PUBLICATION DATE

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S) Forms Standard Letterhead Template Update	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S) n/a
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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 97240, 97241, 97246 REPEAL
TITLE(S) 22	

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"/> Emergency Readopt (Gov. Code, §11346.1(h))	<input checked="" type="checkbox"/> Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
<input type="checkbox"/> Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §11349.3, 11349.4)	<input type="checkbox"/> Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)	<input type="checkbox"/> File & Print	<input type="checkbox"/> Print Only
<input type="checkbox"/> Emergency (Gov. Code, §11346.1(b))		<input type="checkbox"/> Other (Specify) _____	

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"/> State Fire Marshal	
<input type="checkbox"/> Other (Specify) _____			

7. CONTACT PERSON Cristal Schoenfelder	TELEPHONE NUMBER (916) 326-3930	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional) Cristal.Schoenfelder@oshpd.ca.gov
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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 	DATE October 14, 2014
TYPED NAME AND TITLE OF SIGNATORY Ron Spingarn, Deputy Director, Healthcare Information Division	

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

NOV 18 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: 97240, 97241, 97246

Repeal sections:

**NOTICE OF APPROVAL OF CHANGES
WITHOUT REGULATORY EFFECT**

California Code of Regulations, Title 1,
Section 100

OAL File No. 2014-1014-03 N

This action by the Office of Statewide Health Planning and Development makes changes without regulatory effect to sections 97240, 97241 and 97246 in Title 22 of the California Code of Regulations. These changes include formatting changes to forms incorporated by reference and changes to revision dates in the corresponding regulation sections.

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

Date: 11/18/2014



Kevin D. Hull
Senior Attorney

For: DEBRA M. CORNEZ
Director

Original: Robert David
Copy: Cristal Schoenfelder

OSHDP 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 2014~~ 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.

September 18, 2014

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(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.

Office of Statewide Health Planning and Development

Healthcare Information Division

Patient Data Section
400 R Street, Suite 270
Sacramento, California 95811-6213
(916) 326-3935; Fax (916) 322-9555
www.oshpd.ca.gov/HID/MIRCA/

REPEAT



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 _____

Office of Statewide Health Planning and Development

Healthcare Information Division

Patient Data Section
400 R Street, Suite 270
Sacramento, California 95811-6213
(916) 326-3935; Fax (916) 322-2555
www.oshpd.ca.gov/HID/MIRCal/



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:

<input type="checkbox"/> Inpatient
<input type="checkbox"/> Emergency Department
<input type="checkbox"/> 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: _____

Office of Statewide Health Planning and Development

Healthcare Information Division

Patient Data Section
 400 R Street, Suite 270
 Sacramento, California 95811-6213
 (916) 326-3935; Fax (916) 322-9555
 www.oshpd.ca.gov/HID/MIRCaf



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): <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department <input type="checkbox"/> Ambulatory Surgery <small>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.</small>			
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:	

OSHPD Office of Statewide Health Planning and Development

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(916) 326-3935 Fax (916) 327-1262
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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

OSHDP Office of Statewide Health Planning and Development



Healthcare Information Division
Patient Data Section
400 R Street, Suite 270
Sacramento, California 95811-6213
(916) 326-3935 Fax (916) 327-1262
www.oshpd.ca.gov

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:

- | |
|-----------------------------------------------|
| <input type="checkbox"/> Inpatient |
| <input type="checkbox"/> Emergency Department |
| <input type="checkbox"/> 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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Agent Designation Form

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Please print clearly

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

1. FACILITY ID NUMBER:	2. FACILITY NAME:
3. DATA TYPE(S): <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department <input type="checkbox"/> Ambulatory Surgery <small>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.</small>	
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: