

# NONSUBSTANTIVE

STATE OF CALIFORNIA--OFFICE OF ADMINISTRATIVE LAW

## 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 <b>Z-</b>	REGULATORY ACTION NUMBER <b>2016-0613-01N</b>	EMERGENCY NUMBER
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For use by Office of Administrative Law (OAL) only

2016 JUN 13 P 4:50  
OFFICE OF ADMINISTRATIVE LAW

**ENDORSED - FILED**  
In the office of the Secretary of State  
of the State of California

JUL 20 2016  
1:41PM

AGENCY WITH RULEMAKING AUTHORITY <b>Office of Statewide Health Planning and Development</b>	AGENCY FILE NUMBER (if any)
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### 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)
<b>OAL USE ONLY</b> <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 Disapproved/Withdrawn	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE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) <b>OSHPD - Patient Data Section Regulation Updates</b>	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)
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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
97212, 97215, 97225, 97226, 97227, 97228, 97229, 97248, 97252, 97258, 97259, 97260, <del>97261</del> , 97264
TITLE(S)
22 <b>REPEAL 97261 per agency request</b>

3. TYPE OF FILING
<input type="checkbox"/> Regular Rulemaking (Gov. Code §11346) <input type="checkbox"/> Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §511349.3, 11349.4) <input type="checkbox"/> Emergency (Gov. Code, §11346.1(b)) <input type="checkbox"/> Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §511346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute. <input type="checkbox"/> Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1) <input type="checkbox"/> Emergency Readopt (Gov. Code, §11346.1(h)) <input type="checkbox"/> File & Print <input type="checkbox"/> Other (Specify) _____
<input checked="" type="checkbox"/> Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100) <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 56660) <input type="checkbox"/> Fair Political Practices Commission <input type="checkbox"/> State Fire Marshal <input type="checkbox"/> Other (Specify) _____

7. CONTACT PERSON <b>Anthony Tapney</b>	TELEPHONE NUMBER <b>(916) 326-3932</b>	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional) <b>anthony.tapney@oshpd.ca.gov</b>
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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 <i>Ron Spingarn</i>	DATE <b>6-6-16</b>
TYPED NAME AND TITLE OF SIGNATORY <b>Ron Spingarn, Deputy Director</b>	

For use by Office of Administrative Law (OAL) only

**ENDORSED APPROVED**

**JUL 20 2016**

**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:** 97212, 97215, 97225,  
97226, 97227, 97228,  
97229, 97248, 97252,  
97258, 97259, 97260,  
97264

**Repeal sections:** 97261

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

**California Code of Regulations, Title 1,  
Section 100**

**OAL Matter Number: 2016-0613-01**

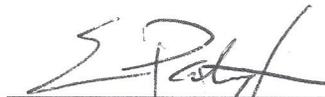
**OAL Matter Type: Nonsubstantive (N)**

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This action by the Office of Statewide Health Planning and Development updates patient data reporting requirements in title 22 of the California Code of Regulations (CCR) by removing obsolete language, correcting cross-references, and harmonizing terminology.

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

**Date:** July 20, 2016



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**Eric Partington  
Attorney**

**For:** Debra M. Cornez  
Director

**Original:** Robert David  
**Copy:** Anthony Tapney

**OSHPD** Office of Statewide Health Planning and Development

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**AMENDMENTS TO REGULATIONS**

## CALIFORNIA CODE OF REGULATIONS

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

Section 97212, 97215, 97225, 97226, 97227, 97228, 97229, 97248, 97252, 97258,  
97259, 97260, 97261, 97264

**97212. Definitions, as Used in This Article.**

- (a) Ambulatory Surgery (AS) Data Record. The Ambulatory Surgery Data Record consists of the set of data elements related to an encounter, as specified in Subsection (a) of Section 128737 of the Health and Safety Code and as defined in Sections 97251-97265 and 97267 of the California Code of Regulations.
- (b) CPT-4. The Current Procedural Terminology, 4th Edition, is published and maintained by the American Medical Association. It is a standard medical code set for healthcare services or procedures in non-inpatient settings.
- (c) Days. Days, as used in this article, are defined as calendar days unless otherwise specified.
- (d) Designated Agent. An entity designated by a reporting facility to submit that reporting facility's data records to the Office's Patient Data Program.
- (e) Discharge. A discharge is defined as an inpatient who:
- (1) is formally released from the care of the hospital and leaves the hospital, or
  - (2) is transferred within the hospital from one type of care to another type of care, as defined by Subsection (x) of Section 97212, or
  - (3) leaves the hospital against medical advice, without a physician's order or is a psychiatric patient who is discharged as away without leave (AWOL), or
  - (4) has died.

(f) Do Not Resuscitate (DNR) Order. A DNR order is a directive from a physician in a patient's current inpatient medical record instructing that the patient is not to be resuscitated in the event of a cardiac or pulmonary arrest. In the event of a cardiac or pulmonary arrest, resuscitative measures include, but are not limited to, the following: cardiopulmonary resuscitation (CPR), intubation, defibrillation, cardioactive drugs, or assisted ventilation.

(g) Emergency Care Data Record. The Emergency Care Data Record consists of the set of data elements related to an encounter, as specified in Subsection (a) of Section 128736 of the Health and Safety Code and as defined in Sections 97251-97265 and 97267.

(h) Emergency Department (ED). Emergency Department means, in a hospital licensed to provide emergency medical services, the location in which those services are provided, as specified in Subsection (be) of Section 128700 of the Health and Safety Code. For the purposes of this chapter, this includes emergency departments providing standby, basic, or comprehensive services.

(i) Encounter. An encounter is a face-to-face contact between an outpatient and a provider.

(j) Error. Error means any record found to have an invalid entry or to contain incomplete data or to contain illogical data.

(k) Facility Identification Number. A unique six-digit number that is assigned to each facility and shall be used to identify the facility.

(l) Freestanding Ambulatory Surgery Clinic. Freestanding ambulatory surgery clinic means a surgical clinic that is licensed by the state under paragraph (1) of subdivision (b) of Section 1204 of the Health and Safety Code. This type of facility is commonly known as a freestanding ambulatory surgery center.

(m) Hospital Discharge Abstract Data Record: The Hospital Discharge Abstract Data Record consists of the set of data elements related to a discharge, as specified in Subsection (g) of Section 128735 of the Health and Safety Code and as defined by Sections 97216-97234 for Inpatients.

~~(n)(1) ICD-9-CM. The International Classification of Diseases, 9th Revision, Clinical Modification, published by the U.S. Department of Health and Human Services. Coding guidelines and annual revisions to ICD-9-CM are made nationally by the "cooperating parties" (the American Hospital Association, the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, and the American Health Information Management Association).~~

(~~12~~) ICD-10-CM. The International Classification of Diseases, Tenth Revision, Clinical Modification, published by the U.S. Department of Health and Human Services. Coding guidelines and annual revisions to ICD-10-CM are made nationally by the “Cooperating Parties” (the American Hospital Association, the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, and the American Health Information Management Association).

(~~23~~) ICD-10-PCS. The International Classification of Diseases, Tenth Revision, Procedure Coding System, published by the U.S. Department of Health and Human Services. Coding guidelines and annual revisions to ICD-10-PCS are made nationally by the “Cooperating Parties” (the American Hospital Association, the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, and the American Health Information Management Association).

(o) Inpatient. An inpatient is defined as a baby born alive in this hospital or a person who was formally admitted to the hospital with the expectation of remaining overnight or longer.

(p) Licensee. Licensee means an entity that has been issued a license to operate a facility as defined by Subsection (~~de~~) or (~~fg~~) of Section 128700 of the Health and Safety Code.

(q) MIRCal. MIRCal means the OSHPD Medical Information Reporting for California system that is the online transmission system through which reports are submitted using an Internet web browser either by file transfer or data entry. It is a secure means of electronic transmission of data in an automated environment and allows facilities to edit and correct data held in a storage database until reports meet or exceed the Approval Criteria specified in Section 97247.

(r) MS-DRG. Medicare Severity Diagnosis Related Groups is a classification scheme with which to categorize inpatients according to clinical coherence and expected resource intensity, as indicated by their diagnoses, procedures, sex, and disposition. It was established and is revised annually by the U.S. Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS).

(s) Outpatient. An outpatient means:

(1) a person who has been registered or accepted for care but not formally admitted as an inpatient and who does not remain over 24 hours, as specified in Subsection (a)(2) of Section 70053 of Title 22 of the California Code of Regulations, or

(2) a patient at a freestanding ambulatory surgery clinic who has been registered and accepted for care.

(t) Provider. A provider is the person who has primary responsibility for assessing and treating the condition of the patient at a given contact and exercises independent judgment in the care of the patient. This would include, but is not limited to, a practitioner licensed as a Medical Doctor (M.D.), a Doctor of Osteopathy, (D.O.), a Doctor of Dental Surgery (D.D.S.), or a Doctor of Podiatric Medicine (D.P.M.).

(u) Record. A record is defined as the set of data elements specified in Subsection (g) of Section 128735, Subsection (a) of Section 128736, or Subsection (a) of Section 128737 of the Health and Safety Code, for one discharge or for one encounter.

(v) Report. A report is defined as the collection of all Hospital Discharge Abstract Data Records, or all Emergency Care Data Records, or all Ambulatory Surgery Data Records required to be submitted by a reporting facility for one reporting period. A report contains only one type of record.

(w) Reporting Facility. Reporting facility means a hospital or a freestanding ambulatory surgery clinic required to submit data records, as specified in Subsection (g) of Section 128735, or Subsection (a) of Section 128736, or Subsection (a) of Section 128737 of the Health and Safety Code.

(x) Type of Care. Type of care in hospitals is defined as one of the following:

(1) Skilled nursing/intermediate care. Skilled nursing/intermediate care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classifications of skilled nursing or intermediate care, as defined by paragraphs (2), (3), or (4) of Subdivision (a) of Section 1250.1 of the Health and Safety Code. Skilled nursing/intermediate care also means inpatient care that is provided to inpatients occupying general acute care beds that are being used to provide skilled nursing/intermediate care to those inpatients in an approved swing bed program.

(2) Physical rehabilitation care. Physical rehabilitation care means inpatient care that is provided to inpatients occupying beds included on a hospital's license within the general acute care classification, as defined by paragraph (1) of Subdivision (a) of Section 1250.1 of the Health and Safety Code, and designated as rehabilitation center beds, as defined by Subsection (a) of Section 70034 and by Section 70595 of Title 22 of the California Code of Regulations.

(3) Psychiatric care. Psychiatric care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classification

of acute psychiatric beds, as defined by paragraph (5) of Subdivision (a) Section 1250.1 of the Health and Safety Code, and psychiatric health facility, as defined by Subdivision (a) of Section 1250.2 of the Health and Safety Code.

(4) Chemical dependency recovery care. Chemical dependency recovery care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license as chemical dependency recovery beds, as defined by paragraph (7) of Subdivision (a) of Section 1250.1 of the Health and Safety Code and Subdivisions (a), (c), or (d) of Section 1250.3 of the Health and Safety Code.

(5) Acute care. Acute care, as defined by paragraph (1) of Subdivision (a) of Section 1250.1 of the Health and Safety Code, means all other types of inpatient care provided to inpatients occupying all other types of licensed beds in a hospital, other than those defined by paragraphs (1), (2), (3) and (4) of Subsection (x) of this section.

(y) User Account Administrator. A healthcare facility representative responsible for maintaining the facility's MIRCal user accounts and user account contact information.

Note: Authority cited: Section 128810, Health and Safety Code. Reference: Sections 1250, 1250.1, 128700, 128735, 128736 and 128737, Health and Safety Code.

#### **97215. Format.**

(a) Hospital Discharge Abstract Data reports 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. For discharges occurring on or after October 1, 2014, up to and including December 31, 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. For discharges occurring on or after January 1, 2015 up to and including December 31, 2016, Hospital Discharge Abstract Data reports shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Inpatient Data Version 2.9 as revised on January 26, 2015 and hereby incorporated by reference. For discharges occurring on or after January 1, 2017, Hospital Discharge Abstract Data reports shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Inpatient Data Version 3.0 as revised on January 30, 2015 and hereby incorporated by reference.~~

(b) Emergency Care Data reports for encounters occurring on or after January 1, 2015, shall comply with the Office's Format and File Specifications for MIRCal Online

Transmission: Emergency Care and Ambulatory Surgery Data Version 1.9, as revised on January 26, 2015 and hereby incorporated by reference.

(c) Ambulatory Surgery Data reports for encounters occurring on or after January 1, 2015, shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Care and Ambulatory Surgery Data Version 1.9, as revised on January 26, 2015 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, 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.~~

(1) For discharges occurring on and after October 1, 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 cited: Section 128810, Health and Safety Code. Reference: Section 128735, Health and Safety Code.

**97226. Definition of Data Element for Inpatients - Other Diagnoses and Present on Admission Indicator.**

(a) ~~(1) For discharges occurring up to and including September 30, 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.~~

(1) For discharges occurring on and after October 1, 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 cited: 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, 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.~~

(12) For discharges occurring on and after October 1, 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) 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 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 cited: 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, 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.~~

(a)b For discharges occurring on and after October 1, 2015, up to and including December 31, 2016: 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.

(b)e For discharges occurring on or after January 1, 2017: 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 4-digit year, the 2-digit month, and the 2-digit day. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Note: Authority cited: 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, 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.~~

~~(ab) For discharges occurring on and after October 1, 2015, up to and including December 31, 2016: 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.~~

~~(be) For discharges occurring on or after January 1, 2017: 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 4-digit year, the 2-digit month, and the 2-digit day. The numeric form for days and months from 1 to 9 must have a zero as the first digit.~~

Note: Authority cited: 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.~~

(12) 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:

<b>Code</b>	<b>Patient Disposition</b>
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.

**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 December 31, 2014.~~

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

<i>Invalid Data Element</i>	<i>Default</i>
<del>Admission date</del>	<del>delete record</del>
<del>Principal Diagnosis</del>	<del>799.9</del>
<del>All other data elements</del>	<del>blank or zero</del>

~~(12) 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 1AB.~~

Table 1AB. Hospital Discharge Abstract Data Record Defaults

<i>Invalid Data Element</i>	<i>Default</i>
Admission date	delete record
All other data elements	blank or zero

~~(c)(1) For encounters occurring up to and including 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~~

<i>Invalid Data Element</i>	<i>Default</i>
Service date	delete record
Principal Diagnosis	799.9
All other data elements	blank or zero

~~(12) 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 2AB.~~

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

<i>Invalid Data Element</i>	<i>Default</i>
Service date	delete record
All other data elements	blank or zero

~~(d)(1) For encounters occurring up to and including 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~~

<i>Invalid Data Element</i>	<i>Default</i>
Service date	delete record
Principal Diagnosis	799.9
All other data elements	blank or zero

(12) 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 3AB.

Table 3AB: Ambulatory Surgery Data Record Defaults

<i>Invalid Data Element</i>	<i>Default</i>
Service date	delete record
All other data elements	blank or zero

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

#### **97252. Definition of Data Element for ED and AS - Sex.**

The patient's ~~sex~~gender shall be reported as male, female or unknown. Unknown indicates that the patient's sex was undetermined or not available from the medical record.

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

~~(a)~~ For encounters occurring on and after October 1, 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.

Note: Authority cited: 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, 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.~~

(a) For encounters occurring on and after October 1, 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.

Note: Authority cited: 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, 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.~~

(a) For encounters occurring on and after October 1, 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 cited: 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, 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 first 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 cited: 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.~~

(12) 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:

<b>Code</b>	<b><i>Patient Disposition</i></b>
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.