



**State of California  
Office of Administrative Law**

**In re:**  
**Office of Statewide Health Planning and  
Development**

**NOTICE OF APPROVAL OF REGULATORY  
ACTION**

**Regulatory Action:**

**Government Code Section 11349.3**

**Title 22, California Code of Regulations**

**OAL File No. 2014-0219-01 S**

**Adopt sections:**

**Amend sections:** 97212, 97215, 97225,  
97226, 97227, 97228,  
97229, 97244, 97248,  
97258, 97259, 97260,  
97261

**Repeal sections:**

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The Office of Statewide Health Planning and Development (Office) proposed this action to amend 13 sections under title 22 of the California Code of regulations and to amend two related incorporated by reference documents. The proposed amendments change the requirement for state licensed hospitals and ambulatory surgery clinics to report certain statutorily required inpatient and outpatient data to the Office using the International Classification of Diseases (ICD) code sets from the ICD-9 version to the ICD-10 version, starting October 1, 2014.

OAL approves this regulatory action pursuant to section 11349.3 of the Government Code. This regulatory action becomes effective on 7/1/2014.

Date: 4/3/2014



Richard L. Smith  
Senior Staff Counsel

For: DEBRA M. CORNEZ  
Director

Original: Robert David  
Copy: Irene Ogbonna

# Exhibit A

## FINAL TEXT

CALIFORNIA CODE OF REGULATIONS  
TITLE 22, DIVISION 7, CHAPTER 10, HEALTH FACILITY DATA  
ARTICLE 8: PATIENT DATA REPORTING REQUIREMENTS Sections 97212, 97215,  
97225, 97226, 97227, 97228, 97229, 97244, 97248, 97258, 97259, 97260, and 97261.

### 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, 4<sup>th</sup> 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 (c) 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).

(2) 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).

(3) 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 (e) or (g) 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.

Authority: 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, 2008 up to and including June 30, 2014 shall comply with the Office's Format and File Specifications for MIRCAl Online Transmission: Inpatient Data, as revised on March 20, 2008 and hereby incorporated by reference. For discharges occurring on or after July 1, 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 ~~September 24, 2012~~ January 1, 2014 and hereby incorporated by reference. This document specifies instructions for discharges occurring July 1, 2014 to

September 30, 2014 and specifies separate instructions for discharges occurring on and after October 1, 2014.

(b) Emergency Care Data reports for encounters occurring on or after January 1, 2009 up to and including September 30, 2014 shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Care and Ambulatory Surgery Data, as revised on March 20, 2008 and hereby incorporated by reference. For encounters occurring on or after October 1, 2014, Emergency Care Data reports shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Care and Ambulatory Surgery Data, as revised on ~~September 24, 2012~~ January 1, 2014 and hereby incorporated by reference.

(c) Ambulatory Surgery Data reports for encounters occurring on or after January 1, 2009 up to and including September 30, 2014 shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Care and Ambulatory Surgery Data, as revised on March 20, 2008. For encounters occurring on or after October 1, 2014, Ambulatory Surgery Data reports shall comply with the Office's Format and File Specifications for MIRCal Online Transmission: Emergency Care and Ambulatory Surgery Data, as revised on ~~September 24, 2012~~ January 1, 2014 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, 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 on admission.
- (4) W. Clinically undetermined. Provider is unable to clinically determine whether or not the condition was present on admission or not.
- (5) (blank) Exempt from present on admission reporting.

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

**97226. Definition of Data Element for Inpatients—Other Diagnosis and 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 admission.
- (4) W. Clinically undetermined. Provider is unable to clinically determine whether or not the condition was present on admission or not.
- (5) (blank) Exempt from present on admission reporting.

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

97227. **Definition of Data Element for Inpatients—~~External Cause of Injury~~ 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 injury morbidity shall be coded according to using the ICD-10-CM External Causes of Morbidity (V00 – V99Y99). The first listed external cause of injury is defined as the cause that resulted in the injury or health condition. 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 admission.
- (4) W Clinically undetermined. Provider is unable to clinically

determine whether or not the condition was present on admission or not.

(5) (blank) Exempt from present on admission reporting.

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

**97228. Definition of Data Element for Inpatients—Principal Procedure and Date.**

(a) For discharges occurring up to and including September 30, 2014: 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.

(b) For discharges occurring on and after October 1, 2014: 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.

Authority: 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, 2014: 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.

(b) For discharges occurring on and after October 1, 2014: 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.-

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

#### **97244. Method of Submission.**

(a) Reporting facilities shall use the MIRCAl system for submitting reports. Data shall be reported utilizing a Microsoft Internet Explorer web browser that supports a secure Internet connection utilizing the Secure Hypertext Transfer Protocol (HTTPS or https) and 128-bit cypher strength Secure Socket Layer (SSL) through either:

- (1) Online transmission of data reports as electronic data files, or
- (2) Online entry of individual records.

(b)(1) For Hospital Discharge Abstract Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report discharges occurring on or after January 1, 2009, up to and including June 30, 2014, by diskette or compact disk provided the hospital complies with the Office's Format and File Specifications for MIRCAl Online Transmission: Inpatient Data, as revised on March 20, 2008.

(2)(1) For Hospital Discharge Abstract Data Reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report discharges occurring on or after July 1, 2014, by diskette or compact disk provided the hospital complies with the Office's Format and File Specifications for MIRCAl Online Transmission: Inpatient Data, as revised on ~~September 24, 2012~~ January 1, 2014. This document specifies instructions for discharges occurring July 1, 2014 to September 30, 2014 and specifies separate instructions for discharges occurring on and after October 1, 2014.

(c)(1) For Emergency Care Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report encounters on or after January 1, 2009, up to and including September 30, 2014, by diskette or compact disk provided the hospital complies with the Office's Format and File Specifications for MIRCAl Online Transmission: Emergency Department and Ambulatory Surgery, revised March 20, 2008.

(2)(1) For Emergency Care Data reports: If an approved exemption is on

file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report discharges occurring on or after October 1, 2014, by diskette or compact disk provided the hospital complies with the Office's Format and File Specifications for MIRCAl Online Transmission: Emergency Department and Ambulatory Surgery, as revised on ~~September 24, 2012~~ January 1, 2014.

(d)(1) For Ambulatory Surgery Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report encounters on or after January 1, 2009, up to and including September 30, 2014, by diskette or compact disk provided the hospital or freestanding ambulatory surgery clinic complies with the Office's Format and File Specifications for MIRCAl Online Transmission: Emergency Department and Ambulatory Surgery, revised March 20, 2008.

(2)(4) For Ambulatory Surgery Data reports: If an approved exemption is on file with the Office, pursuant to Health and Safety Code Section 128755, a hospital may report discharges occurring on or after October 1, 2014, by diskette or compact disk provided the hospital complies with the Office's Format and File Specifications for MIRCAl Online Transmission: Emergency Department and Ambulatory Surgery, as revised on ~~September 24, 2012~~ January 1, 2014.

Note: Authority cited: Section 128755, Health and Safety Code.

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

**97248. Error Tolerance Level.**

(a) The Error Tolerance Level (ETL) for data reported to the Office shall be no more than 2%. Errors as defined in Subsection (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 1 for discharges reported on and after July 1, 2008 up to, and including, discharges occurring on September 30, 2014.

Table 1. Hospital Discharge Abstract Data Record Defaults

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

(2) For discharges occurring on and after October 1, 2014: 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 1.-

Table 1. Hospital Discharge Abstract Data Record Defaults

<u><i>Invalid Data Element</i></u>	<u><i>Default</i></u>
<u>Admission date</u>	<u>delete record</u>
<u>Principal Diagnosis</u>	<u>R69</u>

All other data elements

blank or zero

(c)(1) For encounters occurring up to and including September 30, 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 2.

Table 2: 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

(2) For encounters occurring on and after October 1, 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 2.

Table 2: Emergency Care Data Record Defaults

<u><i>Invalid Data Element</i></u>	<u><i>Default</i></u>
<u>Service date</u>	<u>delete record</u>
<u>Principal Diagnosis</u>	<u>R69</u>
<u>All other data elements</u>	<u>blank or zero</u>

(d)(1) For encounters occurring up to and including September 30, 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 3.

Table 3: 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

(2) For encounters reported on and after October 1, 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 3.

Table 3: Ambulatory Surgery Data Record Defaults

<u><i>Invalid Data Element</i></u>	<u><i>Default</i></u>
<u>Service date</u>	<u>delete record</u>
<u>Principal Diagnosis</u>	<u>R69</u>
<u>All other data elements</u>	<u>blank or zero</u>

Authority: Section 128755, 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, 2014: 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.

(b) For encounters occurring on and after October 1, 2014: 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.

Authority: 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, 2014: 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.

(b) For encounters occurring on and after October 1, 2014: 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.

Authority: Section 128810, Health and Safety Code.

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

**97260. Definition of Data Element for ED and AS—~~Principal External Cause of Injury~~ External Causes of Morbidity.**

(a) For encounters occurring 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 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.

~~(b) For encounters occurring on and after October 1, 2014: The principal external cause of injury is defined as the cause that resulted in the injury or health condition. The external causes of injury 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: 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, 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 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.

~~(b) For encounters occurring on and after October 1, 2014: The other external cause of injury is defined as the causes of morbidity, in addition to the Principal External Cause of Injury, necessary to describe the mechanisms that contributed to, or the causal events surrounding the injury or health condition. The external causes of injury shall be coded according to the ICD-10-CM External Causes of Morbidity (V00-Y99).~~

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