APPENDIX F

CALIFORNIA HEALTH AND SAFETY CODE

DIVISION 107. STATEWIDE HEALTH PLANNING AND DEVELOPMENT

PART 5. HEALTH DATA

Chapter 1. Health Facility Data

[Part 5 was added by Stat.1995, c. 415 (S.B. 1360), § 9.]

Section	Title
128675.	Popular name of chapter.
128680.	Legislative findings, declaration and intent.
128685.	Intermediate care facilities/developmentally disabled - habilitative; exempt from health data and advisory council consolidation act.
128690.	Intermediate care facilities/developmentally disabled - nursing; exemption.
128695.	California health policy and data advisory commission; creation; membership; terms.
128700.	Definitions.
128705.	Reference to Advisory Health Council.
128710.	Meetings.
128715.	Per diem and expenses.
128720.	Executive secretary; staff to commission.
128725.	Powers and duties of commission; appointment and duties of committees; office and commission disagreements.
128730.	Single state agency; collection of health facility or clinical data; consolidation of reports.
128735.	Health facilities; reports and forms; patient's rights of confidentiality; exemptions from disclosure requirements; civil immunity of certain persons required to report data; hospital discharge abstract data record.
128740.	Quarterly summary financial and utilization data reports; contents; copies; charity care service guidelines; operative date.
128745.	Annual risk-adjusted outcome reports; schedule; criteria; groupings.
128750.	Preliminary report to hospital included in annual outcome report; explanatory statement; additional information; technical advisory committee duties.
128755.	Time for filing reports required by §§ 128730, 128735; copies.
128760.	Health facilities; accounting and auditing systems; modifications to discharge data reporting requirements; reporting provisions; county hospital systems financial reporting requirements.

APPENDIX F

Section	Title
128765.	File of reports; public inspection; certified copies; summaries; public liaison.
128770.	Penalties; disposition.
128775.	Petition for review; hearing; judicial review; subpoena powers.
128780.	District hospitals; completeness of disclosure.
128782.	Small and rural hospital - electronic filing requirements.
128785.	Regulations to remain in effect.
128790.	Transfer of funds.
128795.	Transfer of officers and employees other than temporary employees.
128800.	Transfer of real and personal property of California health facilities commission.
128805.	Contracts.
128810.	Administration; rules and regulations.
128815.	Duration of part.

APPENDIX F

§ 128675. Popular name of part

This part shall be known as the Health Data and Advisory Council Consolidation Act.

(Added by Stats. 1984, c. 1326, § 7.)

§ 128680. Legislative findings, declarations and intent

The Legislature hereby finds and declares that:

(a) Significant changes have taken place in recent years in the health care marketplace and in the manner in which health facilities are reimbursed by government and private third party payers for the services they provide.

(b) These changes have permitted the state to reevaluate the need for, and manner in which data are collected from health facilities by the various state agencies and commissions.

(c) It is the intent of the Legislature that as a result of this reevaluation that the data collection function be consolidated in the single state agency. It is the further intent of the Legislature that the single state agency only collect that data from health facilities which are essential. The data should be collected, to the extent practical on consolidated, multipurpose report forms for use by all state agencies.

(d) It is the further intent of the Legislature to eliminate the California Health Facilities Commission and the State Advisory Health Council, and to create a single advisory commission to assume consolidated data collection and planning functions.

(e) It is the Legislature's further intent that the review of the data that the state collects be an ongoing function. The office, with the advice of the advisory commission, shall annually review this data for need and shall revise, add, or delete items as necessary. The commission and the office shall consult with affected state agencies and the affected industry when adding or eliminating data items. However, the office shall neither add nor delete data items to the Hospital Discharge Abstract Data Record or the quarterly reports without prior authorizing legislation, unless specifically required by federal law or judicial decision.

(f) The Legislature recognizes that the authority for the California Health Facilities Commission is scheduled to expire January 1, 1986. It is the intent of the Legislature, by the enactment of this part, to continue the uniform system of accounting and reporting established by the commission

APPENDIX F

and required for use by health facilities. It is also the intent of the Legislature to continue an appropriate, cost-disclosure program.

(Added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1985, c. 1021, § 1.5.)

§ 128685. Intermediate care facilities/developmentally disabled - habilitative; exempt from health data and advisory council consolidation act

Intermediate care facilities/developmentally disabled - habilitative, as defined in subdivision (e) of Section 1250, are not subject to this part.

(Added by Stats. 1995, c. 415 (S.B.1360), §9. Formerly § 441.21, added by Stats. 1987, c. 1456, § 1. Renumbered § 443.15 and amended by Stats. 1990, c. 216 (S.B.2510), § 49.)

§ 128690. Intermediate care facilities/developmentally disabled - nursing; exemption

Intermediate care facilities/developmentally disabled - nursing, as defined in subdivision (h) of Section 1250, are not subject to this part.

(Added by Stats. 1995, c. 415 (S.B.1360), §9. Formerly § 441.22, added by Stats. 1985, c. 1496, § 3. Renumbered § 443.16 and amended by Stats. 1990, c. 216 (S.B.2510), § 50.)

§ 128695. California health policy and data advisory commission; creation; membership; terms

There is hereby created the California Health Policy and Data Advisory Commission to be composed of 11 members.

The Governor shall appoint seven members, one of whom shall be a hospital chief executive officer, one of whom shall be a long-term care facility chief executive officer, one of whom shall be a representative of the health insurance industry involved in establishing premiums or underwriting, one of whom shall be a representative of a group prepayment health care service plan, one of whom shall be a representative of a business coalition concerned with health, and two of whom shall be general members. The Speaker of the Assembly shall appoint two members, one of whom shall be a physician and surgeon and one of whom shall be a general member. The Senate Rules Committee shall appoint two members, one of whom shall be a representative of a labor coalition concerned with health, and one of whom shall be a general member.

The chairperson shall be designated by the Governor. The Governor shall designate four original

APPENDIX F

appointments which will be for four-year terms. The Governor shall designate three original appointments which shall be for two-year terms. The Speaker of the Assembly shall designate one original appointment which will be for two years and one original appointment which will be for four years. The Senate Rules Committee shall designate one original appointment which will be for two years and one original appointment which will be four years. Thereafter, all appointments shall be for four-year terms

In addition to the 11 original appointees to the commission, the chairperson of the Advisory Health Council on December 31, 1985, and the chairperson of the California Health Facilities Commission on December 31, 1985, shall also serve four-year terms. During their terms when the commission shall have 13 members, they shall be full voting representatives.

(Added by Stats. 1984, c. 1326, § 7.)

§ 128700. Definitions

As used in this part, the following terms mean:

(a) "Commission" means the California Health Policy and Data Advisory Commission.

(b) "Health facility" or "health facilities" means all health facilities required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

(c) "Hospital" means all health facilities except skilled nursing, intermediate care, and congregate living health facilities.

(d) "Office" means the Office of Statewide Health Planning and Development.

(e) "Risk-adjusted outcomes" means the clinical outcomes of patients grouped by diagnoses or procedures which have been adjusted for demographic and clinical factors.

(Added by Stats. 1985, c. 1021, § 2. Amended by Stats. 1988, c. 1478 § 2. eff. Sept. 28, 1988. Amended by Stats. 1991, c. 1075 (A.B. 524), § 2.)

§ 128705.. Reference to Advisory Health Council

On and after January 1, 1986, any reference in this code to the Advisory Health Council shall be deemed a reference to the California Health Policy and Data Advisory Commission.

APPENDIX F

(Added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1989, C. 898, § 4.)

APPENDIX F

§ 128710. Meetings

The California Health Policy and Data Advisory Commission shall meet at least once every two months, or more often if necessary to fulfill its duties.

(Added by Stats. 1984, c. 1326, § 7.)

§ 128715. Per diem and expenses

The members of the commission shall receive per diem of one hundred dollars ($100) for each day actually spent in the discharge of official duties and shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the commission.

(Added by Stats. 1984, c. 1326, §.)

§ 128720. Executive Secretary; staff to commission

The commission may appoint an executive secretary subject to approval by the Secretary of Health and Welfare. The office shall provide such other staff to the commission as the office and the commission deem necessary.

(Added by Stats. 1984, c. 1326, § 7.)

§ 128725.. Powers and duties of commission; appointment and duties of committees; office and commission disagreements

The functions and duties of the commission shall include the following:

(a) Advise the office on the implementation of the new, consolidated data system.

(b) Advise the office regarding the ongoing need to collect and report health facility data and other provider data.

(c) Annually develop a report to the director of the Office regarding changes that should be made to existing data collection systems and forms. Copies of the report shall be provided to the Senate Health and Human Services Committee and to the Assembly Health Committee.

(d) Advise the office regarding changes to the uniform accounting and reporting systems for health facilities.

APPENDIX F

APPENDIX F

(e) Conduct public meetings for the purposes of obtaining input from health facilities, other providers, data users, and the general public regarding this chapter and Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.

(f) Advise the Secretary of Health and Welfare on the formulation of general policies which shall advance the purposes of this part.

(g) Advise the office on the adoption, amendment, or repeal of regulations it proposes prior to their submittal to the Office of Administrative Law.

(h) Advise the office on the format of individual health facility or other provider data reports and on any technical and procedural issues necessary to implement this part.

(i) Advise the office on the formulation of general policies which shall advance the purposes of Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.

(j) Recommend, in consultation with a 12-member technical advisory committee appointed by the chairperson of the commission, to the office the data elements necessary for the production of outcome reports required by Section 128745.

(k)(1) The technical advisory committee appointed pursuant to subdivision (j) shall be composed of two members who shall be hospital representatives appointed from a list of at least six persons nominated by the California Association of Hospitals and Health Systems, two members who shall be physicians and surgeons appointed from a list of at least six persons nominated by the California Medical Association, two members who shall be registered nurses appointed from a list of at least six persons nominated by the California Nurses Association, one medical record practitioner who shall be appointed from a list of at least six persons nominated by the California Health Information Association, one member who shall be a representative of a hospital authorized to report as a group pursuant to subdivision (d) of Section 128760, two members who shall be representative of California research organizations experienced in effectiveness review of medical procedures or surgical procedures, or both procedures, one member representing the Health Access Foundation, and one member representing the Consumers Union. Members of the technical advisory committee shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the technical advisory committee.

(2) The commission shall submit its recommendation to the office regarding the first of the reports required pursuant to subdivision (a) of Section 128745 no later than January 1, 1993. The technical advisory committee shall submit its initial recommendations to the commission pursuant to subdivision (d) of Section 128750 no later than January 1, 1994. The commission, with the advice of the technical

advisory committee, may periodically make additional recommendations under Sections 128745 and 128750 to the office, as appropriate.

(l)(1) Assess the value and usefulness of the reports required by Sections 127285, 128735, and 128740. On or before December 1, 1997, the commission shall submit recommendations to the office to accomplish all of the following.

(A) Eliminate redundant reporting.

(B) Eliminate collection of unnecessary data.

(C) Augment data bases as deemed valuable to enhance the quality and usefulness of data.

(D) Standardize data elements and definitions with other health data collection programs at both the state and national levels.

(E) Enable linkage with, and utilization of, existing data sets.

(F) Improve the methodology and data bases used for quality assessment analyses, including, but not limited to, risk-adjusted outcome reports.

(G) Improve the timeliness of reporting and public disclosure.

(2) The commission shall establish a committee to implement the evaluation process. The committee shall include representatives from the health care industry, providers, consumers, payers, purchasers, and government entities, including the Department of Corporations, the departments that comprise the Health and Welfare Agency, and others deemed by the commission to be appropriate to the evaluation of the data bases. The committee may establish subcommittees including technical experts.

(m)(1) As the office and the commission deem necessary, the commission may establish committees and appoint persons who are not members of the commission to these committees as are necessary to carry out the purposes of the commission. Representatives of area health planning agencies shall be invited, as appropriate, to serve on committees established by the office and the commission relative to the duties and responsibilities of area health planning agencies. Members of the standing committees shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of these committees.

(2) Whenever the office or the commission does not accept the advice of the other body on proposed regulations or on major policy issues, the office or the commission shall provide a written

APPENDIX F

response on its action to the other body within 30 days, if so requested.

APPENDIX F

(3) The commission or the office director may appeal to the Secretary of Health and Welfare over disagreements on policy, procedural, or technical issues.

(Added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1991, c. 1075, (A.B. 524) § 3; Stats. 1995, c. 543 (S.B. 1109), § 2, eff. Oct. 4, 1995; Stats. 1996, c. 1023 (S.B. 1497), § 141, eff. Sept. 26, 1996.)

§ 128730. Single state agency; collection of health facility or clinical data; consolidation of reports

(a) Effective January 1, 1986, The Office of Statewide Health Planning and Development shall be the single state agency designated to collect the following health facility or clinic data for use by all state agencies:

(1) That data required by the office pursuant to Section 127285.

(2) That data required in the Medi-Cal cost reports pursuant to Section 14170 of the Welfare and Institutions Code.

(3) Those data items formerly required by the California Health Facilities Commission that are listed in Sections 128735 and 128740. Information collected pursuant to subdivision (g) of Section 128735 shall be made available to the State Department of Health Services. The state department shall ensure that the patient's rights to confidentiality shall not be violated in any manner. The state department shall comply with all applicable policies and requirements involving review and oversight by the State Committee for the Protection of Human Subjects.

(b) The office shall consolidate any and all of the reports listed under this section or Sections 128735 and 128740, to the extent feasible, to minimize the reporting burdens on hospitals. Provided, however, that the office shall neither add nor delete data items from the Hospital Discharge Abstract Data Record or the quarterly reports without prior authorizing legislation, unless specifically required by federal law or regulation or judicial decision.

(Added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1994, c. 1063 (A.B. 3639), § 1.)

§ 128735. Health facilities; reports and forms; patient's rights of confidentiality; exemptions from disclosure requirements; civil immunity of certain persons required to report data; hospital discharge abstract data record

Every organization which operates, conducts, or maintains a health facility and the officers thereof, shall make and file with the office, at the times as the office shall require, all of the following reports on

APPENDIX F

forms specified by the office which shall be in accord where applicable with the systems of accounting and uniform reporting required by this part, except the reports required pursuant to subdivision (g) shall be limited to hospitals:

(a) A balance sheet detailing the assets, liabilities, and net worth of the health facility at the end of its fiscal year.

(b) A statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census.

(c) A statement detailing patient revenue by payer, including, but not limited to, Medicare, Medi-Cal, and other payers, and revenue center except that hospitals authorized to report as a group pursuant to subdivision (d) of Section 128760 are not required to report revenue by revenue center.

(d) A statement of cash-flows, including, but not limited to, ongoing and new capital expenditures and depreciation.

(e) A statement reporting the information required in subdivisions (a), (b), (c), and (d) for each separately licensed health facility operated, conducted, or maintained by the reporting organization, except those hospitals authorized to report as a group pursuant to subdivision (d) of Section 128760.

(f) The office shall consult with the County Hospital Committee of the California Hospital Association, the County Supervisors Association of California, and the California Association of Public Hospitals to improve the accuracy of indigent care revenue reporting and shall present legislative or regulatory recommendations for such improvements by March 30, 1985.

(g) A Hospital Discharge Abstract Data Record which includes all of the following:

(1) Date of birth.

(2) Sex.

(3) Race.

(4) ZIP Code.

(5) Patient social security number, if it is contained in the patient's medical record.

(6) Prehospital care and resuscitation, if any, including all of the following:

APPENDIX F

(A) "Do not resuscitate" (DNR) order at admission.
(B) "Do not resuscitate" (DNR) order after admission.

(7) Admission date.

(8) Source of admission.

(9) Type of admission.

(10) Discharge date.

(11) Principal diagnosis and whether the condition was present at admission.

(12) Other diagnoses and whether the conditions were present at admission.

(13) External cause of injury.

(14) Principal procedure and date.

(15) Other procedures and dates.

(16) Total charges.

(17) Disposition of patient.

(18) Expected source of payment.

It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of a individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(h) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (g).

A hospital or its designee shall semiannually file the Hospital Discharge Abstract Data Record not later than six months after the end of each semiannual period, commencing six months after January 1, 1986.

APPENDIX F

A hospital may submit the Hospital Discharge Abstract Data Record in a computer tape format, and a hospital shall use coding from the International Classification of Diseases in reporting diagnoses and procedures.

(Added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1984, c. 1338, § 1, operative January 1, 1985; Stats. 1985, c. 756, § 1; Stats. 1985, c. 1021, § 4; Stats. 1988, c. 1140,§ 1. Amended by Stats. 1993, c. 249 (S.B. 495), § 1; Stats. 1994, c. 1063 (A.B. 3639),§ 2 Stats. 1996, c. 1025 (S.B. 1659), § 2.)

§ 128740. Quarterly summary financial and utilization data reports; contents; copies; charity care service guidelines; operative date

(a) Commencing with the first calendar quarter of 1992, the following summary financial and utilization data shall be reported to the office by each hospital within 45 days of the end of every calendar quarter. Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal or calendar year. The quarterly summary financial and utilization data shall conform to the uniform description of accounts as contained in the Accounting and Reporting Manual for California Hospitals and shall include all of the following:

(1) Number of licensed beds.

(2) Average number of available beds.

(3) Average number of staffed beds.

(4) Number of discharges.

(5) Number of inpatient days.

(6) Number of outpatient visits.

(7) Total operating expenses.

(8) Total inpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(9) Total outpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

APPENDIX F

(10) Deductions from revenue in total and by component, including the following: Medicare contractual adjustments, Medi-Cal contractual adjustments, and county indigent program contractual adjustments, other contractual adjustments, bad debts, charity care, restricted donations and subsidies for indigents, support for clinical teaching, teaching allowances, and other deductions.

(11) Total capital expenditures.

(12) Total net fixed assets.

(13) Total number of inpatient days, outpatient visits, and discharges by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, self-pay, charity, and other payers.

(14) Total net patient revenues by payer including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(15) Other operating revenue.

(16) Nonoperating revenue net of nonoperating expenses.

(b) Hospitals reporting pursuant to subdivision (d) of Section 128760 may provide the items in paragraphs (7), (8), (9), (10), (14), (15), and (16) of subdivision (a) on a group basis, as described in subdivision (d) of Section 128760.

(c) The office shall make available at cost, to all interested parties, a hard copy of any hospital report made pursuant to this section and in addition to hard copies, shall make available at cost, a computer tape of all reports made pursuant to this section within 105 days of the end of every calendar quarter.

(d) The office, with the advice of the commission, shall adopt by regulation guidelines for the identification, assessment, and reporting of charity care services. In establishing the guidelines, the office shall consider the principles and practices recommended by professional health care industry accounting associations for differentiating between charity services and bad debts. The office shall further conduct the onsite validations of health facility accounting and reporting procedures and records as are necessary to assure that reported data are consistent with regulatory guidelines.

This section shall become operative January 1, 1992.

(Amended by Stats. 1990, c. 51 (A.B. 1154), § 1.5 eff. April 18, 1990, c. 51 (A.B. 1154), § 2, eff. April 18, 1990, Stats. 1991, c. 278 (A.B. 99), § 1.4, eff. July 30, 1991. operative July 1, 1991; Stats. 1991, c.278 (A.B. 99), § 1.5 eff. July 30, 1991, operative Jan. 1, 1992)

§ 128745.. Annual risk-adjusted outcome reports; schedule; criteria; groupings

(a) Commencing July 1993, and annually thereafter, the office shall publish risk-adjusted outcome reports in accordance with the following schedule:

APPENDIX F

Procedures and Publication Date	Period Covered	Conditions Covered
July 1993	1988-90	3
July 1994	1989-91	6
July 1995	1990-92	9

Reports for subsequent years shall include conditions and procedures and cover periods as appropriate.

(b) The procedures and conditions to be reported shall be divided equally among medical, surgical and obstetric conditions or procedures and shall be selected by the office, based on the recommendations of the commission and the advice of the technical advisory committee set forth in subdivision (j) of Section 128725. The selections shall be in accordance with all of the following criteria:

(1) The patient discharge abstract contains sufficient data to undertake a valid risk adjustment.

(2) The relative importance of the procedure and condition in terms of the cost of cases and the number of cases.

(3) Ability to measure outcome and the likelihood that care influences outcome.

(4) Reliability of the diagnostic and procedure data.

(c) The annual reports shall compare the risk-adjusted outcomes experienced by all patients treated for the selected conditions and procedures in each California hospital during the period covered by each report, to the outcomes expected. Outcomes shall be reported in the five following groupings:

(1) "Much higher than average outcomes," for hospitals with risk-adjusted outcomes much higher than the norm.

(2) "Higher than average outcomes," for hospitals with risk-adjusted outcomes higher than the norm.

(3) "Average outcomes," for hospitals with average risk-adjusted outcomes.

(4) "Lower than average outcomes," for hospitals with risk-adjusted outcomes lower than the norm.

APPENDIX F

(5) "Much lower than average outcomes," for hospitals with risk-adjusted outcomes much lower than the norm.

(Added by Stats. 1991, c. 1075 (A.B. 524), § 4.)

§ 128750. Preliminary report to hospital included in annual outcome report; explanatory statement; additional information; technical advisory committee duties

(a) Prior to the public release of the annual outcome reports the office shall furnish a preliminary report to each hospital that is included in the report. The office shall allow the hospital and chief of staff 60 days in which to review the outcome scores and compare the scores to other California hospitals. A hospital or its chief of staff that believes that the risk-adjusted outcomes do not accurately reflect the quality of care provided by the hospital may submit a statement to the office, within the 60 days, explaining why the outcomes do not accurately reflect the quality of care provided by the hospital. The statement shall be included in an appendix to the public report, and a notation that the hospital or its chief of staff has submitted a statement shall be displayed wherever the report presents outcome scores for the hospital.

(b) The office shall, in addition to public reports, provide hospitals and the chiefs of staff of the medical staffs with a report containing additional detailed information derived from data summarized in the public outcome reports as an aid to internal quality assurance.

(c) If, pursuant to the recommendations of the office, based on the advice of the commission, in response to the recommendations of the technical advisory committee made pursuant to subdivision (d) of this section, the Legislature subsequently amends Section 128735 to authorize the collection of additional discharge data elements, then the outcome reports for conditions and procedures for which sufficient data is not available for the current abstract record will be produced following the collection and analysis of the additional data elements.

(d) The recommendations of the technical advisory committee for the addition of data elements to the discharge abstract should take into consideration the technical feasibility of developing reliable risk-adjustment factors for additional procedures and conditions as determined by the technical advisory committee with the advice of the research community, physicians and surgeons, hospitals, and medical records personnel.

(e) The technical advisory committee at a minimum shall identify a limited set of core clinical data elements to be collected for all of the added procedures and conditions and unique clinical variables necessary for risk adjustment of specific conditions and procedures selected for the outcomes report program. In addition, the committee should give careful consideration to the costs associated with the

additional data collection and the value of the specific information to be collected.

(f) The technical advisory committee shall also engage in a continuing process of data development and refinement applicable to both current and prospective outcome studies.

(Added by Stats. 1991, c. 1075 (A.B. 524), § 5.)

§ 128755. Reports required by §§ 128730, 128735; filing; availability

(a)(1) Hospitals shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the office within four months after the close of the hospital's fiscal year except as provided in paragraph (2).

(2) If a licensee relinquishes the facility license or puts the facility license in suspense, the last day of active licensure shall be deemed a fiscal year end.

(3) The office shall make the reports filed pursuant to this subdivision available no later than three months after they were filed.

(b)(1) Skilled nursing facilities, intermediate care facilities, intermediate care facilities/developmentally disabled, and congregate living facilities, including nursing facilities certified by the state department to participate in the Medi-Cal program, shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the office within four months after the close of the facility's fiscal year, except as provided in paragraph (2).

(2)(A) If a licensee relinquishes the facility license or puts the facility licensure in suspense, the last day of active licensure shall be deemed a fiscal year end.

(B) If a fiscal year end is created because the facility license is relinquished or put in suspense, the facility shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 within two months after the last day of active licensure.

(3) The office shall make the reports filed pursuant to paragraph (1) available not later than three months after they are filed.

(4)(A) Effective for fiscal years ending on or after December 31, 1991, the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 shall be filed with the office by electronic media, as determined by the office.

APPENDIX F

(B) Congregate living health facilities are exempt from the electronic media reporting requirements of subparagraph (A).

(c) The reports required by subdivision (g) of Section 128735 shall be filed semiannually by each hospital or its designee not later than six months after the end of each semiannual period,

commencing six months after January 1, 1986, and shall be available from the office no later than six months after the date upon which the report was filed.

(d) The reports referred to in paragraph (2) of subdivision (a) of Section 128730 shall be filed with the office on the dates required by applicable law and shall be available from the office no later than six months after the date upon which the report was filed.

(e) The office shall make available at cost, to all interested parties, a hard copy of any health facility report referred to in subdivision (a), (b), (c), (d), or (g) of Section 128735 and in addition to hard copies, shall make available at cost, computer tapes of the health facility reports referred to in subdivision (a), (b), (c), (d), or (g) of Section 128735, unless the office determines that an individual patient's rights of confidentiality would be violated.

(Added by Stats. 1995, c. 415 (S.B.1360) § 9. Former § 443.33, added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1985, c. 1021, § 7; Stats. 1988, c. 1140, § 2. Amended by Stats. 1990, c. 502, § 1, eff. Aug. 10, 1990.)

§ 128760. Health facilities; accounting and auditing systems; modifications to discharge data reporting requirements; reporting provisions; county hospital systems financial reporting requirements

(a) On and after January 1, 1986, those systems of health facility accounting and auditing formerly approved by the California Health Facilities Commission shall remain in full force and effect for use by health facilities but shall be maintained by the office with the advice of the Health Policy and Data Advisory Commission.

(b) The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications in the accounting and reporting systems for use by health facilities in meeting the requirements of this part if the modifications are necessary to do any of the following:

(1) To correctly reflect differences in size of, provision of, or payment for, services rendered by

APPENDIX F

health facilities.

(2) To correctly reflect differences in scope, type, or method of provision of, or payment for, services rendered by health facilities.

(3) To avoid unduly burdensome costs for those health facilities in meeting the requirements of differences pursuant to paragraphs (1) and (2).

(c) Modifications to discharge data reporting requirements. The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for

modifications to discharge data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this part. This modification authority shall not be construed to permit the office to administratively require the reporting of discharge data items not specified in Section 128735.

(d) Reporting provisions for health facilities. The office, with the advice of the commission, shall establish specific reporting provisions for health facilities that receive a preponderance of their revenue from associated comprehensive group-practice prepayment health care service plans. These health facilities shall be authorized to utilize established accounting systems, and to report costs and revenues in a manner which is consistent with the operating principles of these plans and with generally accepted accounting principles. When these health facilities are operated as units of a coordinated group of health facilities under common management, they shall be authorized to report as a group rather than as individual institutions. As a group, they shall submit a consolidated income and expense statement.

Hospitals authorized to report as a group under this subdivision may elect to file cost data reports required under the regulations of the Social Security Administration in its administration of Title XVIII of the federal Social Security Act in lieu of any comparable cost reports required under Section 128735. However, to the extent that cost data is required from other hospitals, the cost data shall be reported for each individual institution.

The office, with the advice of the commission, shall adopt comparable modifications to the financial reporting requirements of this part for county hospital systems consistent with the purposes of this part.

(Added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1984, c. 1338, § 2, operative Jan. 1, 1985; Stats. 1985, c. 756, § 5.)

§ 128765. File of reports; public inspection; certified copies; summaries; public liaison

APPENDIX F

(a) The office, with the advice of the commission, shall maintain a file of all the reports filed under this part at its Sacramento office. Subject to any rules, the office, with the advice of the commission, may prescribe, these reports shall be produced and made available for inspection upon the demand of any person, with the exception of hospital discharge abstract data which shall be available for public inspection unless the office determines that an individual patient's rights of confidentiality would be violated.

(b) Copies certified by the office as being true and correct copies of reports properly filed with the office pursuant to this part, together with summaries, compilations, or supplementary reports prepared by the office, shall be introduced as evidence, where relevant, at any hearing, investigation, or other proceeding held, made, or taken by any state, county, or local

governmental agency, board, or commission which participates as a purchaser of health facility services pursuant to the provisions of a publicly financed state or federal health care program.

Each of these state, county, or local governmental agencies, boards, and commissions shall weigh and consider the reports made available to it pursuant to the provisions of this subdivision in its formulation and implementation of policies, regulations, or procedures regarding reimbursement methods and rates in the administration of these publicly financed programs.

(c) The office, with the advice of the commission, shall compile and publish summaries of the data for the purpose of public disclosure. The commission shall approve the policies and procedures relative to the manner in which data is disclosed to the public. The office, with the advice of the commission, may initiate and conduct studies as it determines will advance the purposes of this part.

(d) In order to assure that accurate and timely data are available to the public in useful formats, the office shall establish a public liaison function. The public liaison shall provide technical assistance to the general public on the uses and applications of individual and aggregate health facility data and shall provide the director and the commission with an annual report on changes that can be made to improve the public's access to data.

(e) In addition to its public liaison function, the office shall continue the publication of aggregate industry and individual health facility cost and operational data published by the California Health Facilities Commission as described in subdivision (b) of Section 441.95 as that section existed on December 31, 1985. This publication shall be submitted to the Legislature not later than March 1 of each year commencing with calendar year 1986 and in addition shall be offered for sale as a public document.

(Added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1985, c. 1021§ 8.)

§ 128770. Penalties; disposition

(a) Any health facility which does not file any report as required by this part with the office is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of any report is delayed. No penalty shall be imposed if an extension is granted in accordance with the guidelines and procedures established by the office, with the advice of the commission.

(b) Any health facility which does not use an approved system of accounting pursuant to the provisions of this part for purposes of submitting financial and statistical reports as required by this part shall be liable for a civil penalty of not more than five thousand dollars ($5,000).

APPENDIX F

(c) Civil penalties are to be assessed and recovered in a civil action brought in the name of the people of the State of California by the office. Assessment of a civil penalty may, at the request of

any health facility, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(d) Any money which is received by the office pursuant to this section shall be paid into the General Fund.

(Added by Stats. 1984, c. 1326, § 7.)

§ 128775. Petition for review; hearing; judicial review; subpoena powers

Text of section operative until July 1, 1997.

Any health facility affected by any determination made under this part by the office may petition the office for review of the decision. This petition shall be filed with the office within 15 business days, or within such greater time as the office, with the advice of the commission, may allow, and shall specifically describe the matters which are disputed by the petitioner.

A hearing shall be commenced within 60 calendar days of the date on which the petition was filed. The hearing shall be held before an employee of the office, an administrative law judge employed by the Office of Administrative Hearings, or a committee of the commission chosen by the chairperson for this purpose. If held before an employee of the office or a committee of the commission, the hearing shall be held in accordance with any procedures as the office, with the advice of the commission, shall prescribe. If held before an administrative law judge employed by the Office of Administrative Hearings, the hearing shall be held in accordance with Chapter 5 (commencing with Section 11500) of Division 3 of Title 2 of the Government Code. The employee, administrative law judge, or committee shall prepare a recommended decision including findings of fact and conclusions of law and present it to the office for its adoption. The decision of the office shall be in writing and shall be final. The decision of the office shall be made within 60 calendar days after the conclusion of the hearing and shall be effective upon filing and service upon the petitioner.

Judicial review of any final action, determination, or decision may be had by any party to the proceedings as provided in Section 1094.5 of the Code of Civil Procedure. The decision of the office shall be upheld against a claim that its findings are not supported by the evidence unless the court determines that the findings are not supported by substantial evidence.

The employee of the office, the administrative law judge employed by the Office of Administrative Hearings, the Office of Administrative Hearings, or the committee of the commission, may issue

APPENDIX F

subpoenas and subpoenas duces tecum in a manner and subject to the conditions established by Section 11510 of the Government Code.

APPENDIX F

(e) This section shall become inoperative on July 1, 1997, and as of January 1, 1998, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 1998, deletes or extends the dates on which it becomes inoperative and is repealed.

(Added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1985, c. 1021, § 9. Amended by Stats. 1995, c. 938 (S.B. 523), § 59; Stats. 1996, c. 1023 (S.B. 1497) § 141.2, eff. Sept. 29, 1996.)

§ 128775. Petition for review; hearing; judicial review; subpoena powers

Text of section operative July 1, 1997.

(a) Any health facility affected by any determination made under this part by the office may petition the office for review of the decision. This petition shall be filed with the office within 15 business days, or within such greater time as the office, with the advice of the commission, may allow, and shall specifically describe the matters which are disputed by the petitioner.

(b) A hearing shall be commenced within 60 calendar days of the date on which the petition was filed. The hearing shall be held before an employee of the office, an administrative law judge employed by the Office of Administrative Hearings, or a committee of the commission chosen by the chairperson for this purpose. If held before an employee of the office or a committee of the commission, the hearing shall be held in accordance with any procedures as the office, with the advice of the commission, shall prescribe. If held before an administrative law judge employed by the Office of Administrative Hearings, the hearing shall be held in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The employee, administrative law judge, or committee shall prepare a recommended decision including findings of fact and conclusions of law and present it to the office for its adoption. The decision of the office shall be in writing and shall be final. The decision of the office shall be made within 60 calendar days after the conclusion of the hearing and shall be effective upon filing and service upon the petitioner.

(c) Judicial review of any final action, determination, or decision may be had by any party to the proceedings as provided in Section 1094.5 of the Code of Civil Procedure. The decision of the office shall be upheld against a claim that its findings are not supported by the evidence unless the court determines that the findings are not supported by substantial evidence.

(d) The employee of the office, the administrative law judge employed by the Office of Administrative Hearings, the Office of Administrative Hearings, or the committee of the commission, may issue subpoenas and subpoenas duces tecum in a manner and subject to the conditions established by Article 11 (commencing with Section 11450.10) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of the

Government Code.

(e) This section shall become operative on July 1, 1997.

(Added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1985, c. 1021, § 9. Amended by Stats. 1995, c. 938 (S.B. 523), § 59, operative July 1, 1997; Stats. 1996, c. 1023 (S.B. 1497) § 141.2, eff. Sept. 29, 1996, operative July 1, 1997.)

§ 128780. District hospitals; completeness of disclosure

Notwithstanding any other provision of law, the disclosure aspects of this part shall be deemed complete with respect to district hospitals, and no district hospital shall be required to report or disclose any additional financial or utilization data to any person or other entity except as is required by this part.

(Added by Stats. 1984, c. 1326, § 7.)

§ 128782. Small and rural hospital - electronic filing requirements

Notwithstanding any other provision of law, upon the request of a small and rural hospital, as defined in Section 1188.855, that did not file financial reports with the office by electronic media as of January 1, 1993, the office shall, on a case-by-case basis, do one of the following:

(a) Exempt the small and rural hospital from any electronic filing requirements of the office regarding annual or quarterly financial disclosure reports specified in Sections 128735 and 128740.

(b) Provide a one-time reduction in the fee charged to the small and rural hospital not to exceed the maximum amount assessed pursuant to Section 127280 by an amount equal to the costs incurred by the small and rural hospital to purchase the computer hardware and software necessary to comply with any electronic filing requirements of the office regarding annual or quarterly financial disclosure reports specified in Sections 128735 and 128740.

(Added by Stats. 1993, c. 249 § 2. Amended by Stats. 1996, c. 1023 (S.B. 1497), § 369, eff. Sept. 29, 1996.)

§ 128785. Regulations to remain in effect

On January 1, 1986, all regulations previously adopted by the California Health Facilities Commission which relate to functions vested in the Office of Statewide Health Planning and Development and which

APPENDIX F

are in effect on that date, shall remain in effect and shall be fully enforceable to the extent that they are consistent with this part, as determined by the office, unless

APPENDIX F

and until readopted, amended, or repealed by the Office of Statewide Health Planning and Development following review and comment by the commission.

(Added by Stats. 1984, c. 1326, § 7.)

§ 128790. Transfer of funds

Pursuant to Section 16304.9 of the Government Code, the Controller shall transfer to the office the unexpended balance of funds as of January 1, 1986, in the California Health Facilities Commission Fund, available for use in connection with the performance of the functions of the California Health Facilities Commission to which it has succeeded pursuant to this part.

(Added by Stats. 1984, c. 1326, § 7.)

§ 128795. Transfer of officers and employees other than temporary employees

All officers and employees of the California Health Facilities Commission who, on December 31, 1985, are serving the state civil service, other than as temporary employees, and engaged in the performance of a function vested in the Office of Statewide Health Planning and Development by this part shall be transferred to the Office of Statewide Health Planning and Development. The status, positions, and rights of such persons shall not be affected by the transfer and shall be retained by them as officers and employees of the Office of Statewide Health Planning and Development, pursuant to the State Civil Service Act except as to positions exempted from civil service.

(Added by Stats. 1984, c. 1326, § 7.)

§ 128800. Transfer of real and personal property of California Health Facilities Commission

The Office of Statewide Health Planning and Development shall have possession and control of all records, papers, offices, equipment, supplies, moneys, funds, appropriations, land, or other property, real or personal, held for the benefit or use of the California Health Facilities Commission for the performance of functions transferred to the Office of Statewide Health Planning and Development by this part.

(Added by Stats. 1984, c. 1326, § 7.)

APPENDIX F

§ 128805. Contracts

The Office of Statewide Health Planning and Development may enter into such agreements and contracts with any person, department, agency, corporation, or legal entity as are necessary to carry out the functions vested in the office by this part or any other law.

(Added by Stats. 1984, c. 1326, § 7.)

§ 128810. Administration; rules and regulations

The office shall administer this part and shall make all rules and regulations necessary to implement the provisions and achieve the purposes stated herein. The commission shall advise and consult with the office in carrying out the administration of this part.

(Added by Stats. 1984, c. 1326, § 7.)

§ 128815. Duration of part

This chapter shall remain in effect only until January 1, 1999, and as of that date is repealed unless a later enacted statute chaptered prior to that date extends or deletes that date.

(Added by Stats. 1984, c. 1326, § 7. Amended by Stats. 1988, c. 1140, § 3; Stats. 1995, c. 543 (S.B. 1109), § 3, eff. Oct. 4, 1995; Stats. 1996, c. 1023 (S.B. 1497), § eff. Sept. 29, 1996.)

[The following section while not within Part 1.8, is relevant to the Health Data and Advisory Council Consolidation Act.]

§ 127280. Special fee charged to health facilities; disposition of fees; failure to pay fees

(a) Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the state, shall be charged a fee of not more than 0.035 percent of the health facility's gross operating cost for the provision of health care services for its last fiscal year ending prior to the effective date of this section. Thereafter the office shall set for, charge to, and collect from all health facilities, except health facilities owned and operated by the state, a special fee, which shall be due on July 1, and delinquent on July 31 of each year beginning with the year 1977, of not more than 0.035 percent of the health facility's gross operating cost for provision of health care services for its last fiscal year which ended on or before June 30 of the preceding calendar year. Each year the office shall establish the fee to produce revenues equal to the appropriation to pay for the

APPENDIX F

functions required to be performed pursuant to this chapter or Chapter 1 (commencing with Section 128675) of Part 5 by the office, the area and local health planning agencies, and the Advisory Health Council.

Health facilities which pay fees shall not be required to pay, directly or indirectly, the share of the costs of those health facilities for which fees are waived.

(b) There is hereby established the California Health Data and Planning Fund within the Office of Statewide Health Planning and Development for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(c) Any amounts raised by the collection of the special fees provided for by subdivision (a) of this section which are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the office and the council in succeeding years when appropriated by the Legislature, for expenditure under the provisions of this chapter, and Chapter 1 (commencing with Section 128675) of Part 5 and shall reduce the amount of the special fees which the office is authorized to establish and charge.

(d) No health facility liable for the payment of fees required by this section shall be issued a license or have an existing license renewed unless the fees are paid. New, previously unlicensed health facilities shall be charged a pro rata fee to be established by the office during the first year of operation.

The license of any health facility, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the office that the fees required were not paid within the time prescribed by subdivision (a).

(Added by Stats. 1995, c. 415 (S.B. 1360), § 9.)

APPENDIX F

TITLE 22, CALIFORNIA CODE OF REGULATIONS

DIVISION 7

CHAPTER 10. HEALTH FACILITY DATA

Article 1. General

Section Title

97003. Accounting System Requirements
97005. Definitions
97007. Notice of Change in Health Facility Fiscal Year, Licensure, Name, Address, or Closure
97008. Notice of New Health Facility Operations

Article 2. Accounting System Requirements

97015. Chart of Accounts
97016. Accrual Accounting
97017. Special Accounting Requirements and Account Codes
97018. Accounting and Reporting Manual for California Hospitals
97019. Accounting and Reporting Manual for California Long-term Care Facilities
97020. Delayed Implementation of LTC Accounting Manual Second Edition
97030. Failure to Meet Accounting Requirements

Article 3. Reporting Requirements

97040. Required Annual Reports
97041. Report Procedure
97042. Comparative Reports
97043. Form of Authentication
97044. Exceptions to Required Reports
97045. Failure to File Required Reports

Article 4. Modification, Extension, and Appeal Processes

97050. Request for Modifications to Approved Accounting and Reporting Systems
97051. Requests for Extension Time to File Required Reports

APPENDIX F

97052. Appeal Procedure
97053. Conduct of Hearing
97054. Decision on Appeal

Article 5. Collection of Special Fees

97062. Notice of Assessment
97063. Basis of Assessment
97064. Exceptions to the Basis of Assessment
97065. Delinquent Special Fees

Article 6. Public Availability of Disclosure Materials

Section Title

97110. Place and Time of Availability
97115. Manner of Requesting Disclosure Materials
97125. Protection of Records

Article 7. (Reserved)

Article 8. Discharge Data Reporting Requirements

97210. Notice of Change in Hospital Reporting Period, Contract Person, Method of Submission or Designated Abstractor
97211. New Hospital Operations
97212. Required Reporting
97213. Request for Modifications to the California Hospital Discharge Data Set
97214. Requests for Extension of Time to File Discharge Data
97215. Error Tolerance Levels
97216. Acceptance Criteria

APPENDIX F

Article 1. General

97003. Accounting System Requirements.

(a) The hospital accounting system prescribed by this Chapter shall be used by all hospitals licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, Health and Safety Code.

(b) The long-term care facility accounting system prescribed by this Chapter shall be used by all skilled nursing facilities, intermediate care facilities, intermediate care facilities/developmentally disabled, and congregate living health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, Health and Safety Code.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128760, Health and Safety Code.

97005. Definitions.

As used in this Chapter:

(a) "Act" means the Health Data and Advisory Council Consolidation Act set forth in Division 1, Part 1.8 (commencing with Section 128675) of the Health and Safety Code.

(b) "Unrestricted funds" mean funds which bear no external restrictions as to use or purpose: i.e., funds which can be used for any legitimate purpose designated by the governing board as distinguished from funds restricted externally.

(c) "Restricted funds" means funds restricted by donors or grantors for specific purposes. The term refers to plant replacement and expansion, specific purpose and endowment funds.

(d) "Long-term care facility" and "long-term care facilities" mean all skilled nursing facilities, intermediate care facilities, intermediate care facilities/developmentally disabled, and congregate living health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, Health and Safety Code.

(e) "Preponderance" means 51 percent or more of gross in-patient revenue. This definition also applies to Section 128760 of the Health and Safety Code.

(f) "Director" means the Director of the Office of Statewide Health Planning and Development.

APPENDIX F

(g) "Health facility" or "health facilities" means all health facilities required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(h) "Health facility gross operating cost for the provision of health care services" (Section 127280(a), Health and Safety Code) means total patient-related operating expenses as reported to the Office for the fiscal years ending on or before June 30 of the previous calendar year on:

(1) Hospital disclosure report CHC 7041 d-1, column 1, line 200, for hospitals, and

(2) Long-term care facility disclosure report CHFC 7041 d-1, column 1, line 200, for long-term care facilities.

(I) "New health facility" means any health facility beginning or resuming operations for the first time within a 12-month period.

(j) Disclosure reports, extension requests, appeal petitions, and other items are deemed to have been "filed" or "submitted" with the Office:

(1) as of the date they are postmarked by the United States Postal Service if properly addressed and postage prepaid;

(2) as of the date they are dated by a commercial carrier if properly addressed and delivery fee prepaid;

(3) when received by the Office via FAX machine or other electronic device;

(4) when received by the Office via hand delivery; or

(5) when otherwise received by the Office.

(k) "Hospital accounting manual", "manual for hospitals" and "hospital manual" mean the "Accounting and Reporting Manual for California Hospitals" published by the Office and more particularly described by Section 97018 of this Chapter.

(l) "Long-term care manual," "manual for long-term care facilities," and "LTC manual" mean the "Accounting and Reporting Manual for California Long-term Care Facilities" published by the Office and more particularly described by Section 97019 of this Chapter.

(m) "Owner" means any individual or organization having a five percent or more equity interest, direct

or indirect, in the entity licensed as a health facility.

(n) "Office" and "OSHPD" mean the Office of Statewide Health Planning and Development.

(o) "Commission" means the California Health Policy and Data Advisory Commission.

(p) "Licensee" means the person, firm, partnership, association, corporation, political subdivision of the state, or other governmental agency within the state licensed to operate a health facility.

Authority: Section 128810, Health and Safety Code.
Reference: Part 1.8 of Division 1 and Section 1253 of the Health and Safety Code.

97007. Notice of Change in Health Facility Fiscal Year, Licensure, Name, Address, or Closure.

(a) Each licensee of a health facility shall notify the Office in writing whenever the health facility fiscal year is changed. Notification shall be made within 30 days of such action by the health facility. The notice shall include the health facility name, street address, and both old and new fiscal year ending dates.

(b) Each licensee of a health facility shall notify the Office in writing within 30 days of the effective date of any change of licensee of the health facility. Such notice shall include the following, as applicable: the old and new names of the health facility, the names of the former and new licensees, permanent or forwarding street and mailing addresses of the former and new licensees, old and new telephone numbers of the health facility, the telephone number of the former licensee if available to the new licensee, the telephone number of the new licensee, the names of the owners having a five percent or more interest in the health facility, the names of the chair and members of the governing body, and the name of the individual in charge of the day-to-day operation of the health facility.

(c) Each licensee of a health facility shall notify the Office in writing within 30 days of any change in the name, telephone number, or street and mailing addresses of the health facility. Such notice shall include the old and new names of the health facility and/or the old and new street and mailing addresses of the health facility, and old and new telephone numbers.

(d) Each licensee of a health facility shall notify the Office in writing within 30 days of any change in the owners having a five percent or more interest in the health facility, in the chair and members of the governing body, and in the individual in charge of the day-to-day operation of the health facility.

APPENDIX F

(e) Each licensee of a health facility shall notify the Office in writing within 30 days of the facility's closure. Such notice shall include the last date patient care was provided, the final date of licensure, the street and mailing address of the health facility, the permanent or forwarding

mailing address of the health facility licensee, and the telephone number of the health facility licensee.

(f) Each licensee of a hospital shall notify the Office in writing within 30 days of the date the license is placed in suspense. Such notice shall include the last date patient care was provided, the date the license was placed in suspense, the street and mailing address of the health facility, the permanent or forwarding mailing address of the health facility licensee, and the telephone number of the health facility licensee.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 127280, 128735, 128740, 128755 and 128760, Health and Safety Code.

97008. Notice of New Health Facility Operations.

Each licensee of a health facility beginning operations, whether in a newly constructed facility or in an existing facility, pursuant to a new license or a license previously in suspense, shall provide the Office the following information in writing within seven days after the effective date of the license: name of health facility, name of licensee, street and mailing addresses of the health facility and the licensee, telephone numbers of the health facility and the licensee including area codes, fiscal year ending date, date when first patients are expected to be admitted, names of the owners having a five percent or more interest in the health facility, names of the chair and members of the governing body, and name of the individual in charge of the day-to-day operation of the health facility.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 127280, 128735, 128740, 128755 and 128760, Health and Safety Code.

Article 2. Accounting System Requirements

97015. Chart of Accounts.

(a) All hospitals shall use in their books of account the Chart of Accounts set forth in the "Accounting and Reporting Manual for California Hospitals" as specified by Section 97018, except as provided herein. If individual requirements for information make further breakdown of an account necessary, hospitals may use subaccounts provided they can be combined into the prescribed account framework for reporting purposes.

APPENDIX F

(b) All long-term care facilities shall use in their books of account the Chart of Accounts set forth in the "Accounting and Reporting Manual for California Long-term Care Facilities" as

specified by Section 97019, except as provided herein. If individual requirements for information make further breakdown of an account necessary, long-term care facilities may use subaccounts provided they can be combined into the prescribed account framework for reporting purposes.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128760, Health and Safety Code.

97016. Accrual Accounting.

A full accrual basis of accounting for revenue and expenses is required for all health facilities. Revenues shall be given recognition in the period during which the service is provided. Except as may be provided in the long-term care manual prescribed by Section 97019, patient revenue shall be recorded at the full established rates regardless of the amounts actually paid to the health facility by or on behalf of the patients. Revenue deductions in all health facilities shall be given accounting recognition in the same period that the related revenues are recorded. Health facility expenses shall be given recognition in the period in which there is (1) a direct identification or association with the revenue of the period, as in the case of services rendered to patients; (2) an indirect association with revenue of the period, as in the case of salaries or rent; or (3) a measurable expiration of asset costs even though not associated with the production of revenue for the current period, as in the case of losses from fire.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128760, Health and Safety Code.

97017. Special Accounting Requirements and Account Codes.

(a) Health facilities shall segregate accounts between unrestricted funds and restricted funds. Within the restricted fund classification shall be such funds as specific purpose funds, endowment funds, plant replacement and expansion funds, and other special purpose funds.

(b) All hospitals shall use in their books and records the account coding structure specified in the "Accounting and Reporting Manual for California Hospitals," as specified by Section 97018.

(c) All long-term care facilities shall use in their books and records the account coding structure specified in the "Accounting and Reporting Manual for California Long-term Care Facilities," as specified by Section 97019.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128760, Health and Safety Code.

APPENDIX F

97018. Accounting and Reporting Manual for California Hospitals.

(a) To assure uniformity of accounting and reporting procedures among California hospitals, the Office shall publish an "Accounting and Reporting Manual for California Hospitals," which shall be supplemental to the system adopted by this Chapter. The "Accounting and Reporting Manual for California Hospitals," effective April 19, 2000, shall not be published in full in the California Code of Regulations, but is hereby incorporated by reference. All hospitals must comply with systems and procedures detailed in the hospital manual. Copies of the "Accounting and Reporting Manual for California Hospitals" may be obtained from the Office at 818 K Street, Room 400, Sacramento, CA 95814. The Office shall provide each new hospital with a copy of the hospital manual. The hospital manual published by the Office shall be the official and binding interpretations of accounting and reporting treatment within the hospital accounting and reporting system.

(b) Requests for modifications to the accounting and reporting systems as set forth by the hospital manual shall be filed as provided under Section 97050.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128760, Health and Safety Code.

97019. Accounting and Reporting Manual for California Long-term Care Facilities.

(a) To assure uniformity of accounting and reporting procedures among long-term care facilities, the Office shall publish an "Accounting and Reporting Manual for California Long-term Care Facilities," which will be supplemental to the system adopted by this Chapter. The "Accounting and Reporting Manual for California Long-term Care Facilities," Second Edition (Manual) as amended November 30, 2000, shall not be published in full in the California Code of Regulations, but is hereby incorporated by reference. All long-term care facilities must comply with the systems and procedures detailed in the Manual. Copies of the Manual may be obtained from the Office at 818 K Street, Room 400, Sacramento, CA 95814. The Office shall provide each new long-term care facility with a copy of the "Accounting and Reporting Manual for California Long-term Care Facilities." The Manual published by the Office shall be the official and binding interpretations of accounting and reporting treatment within the long-term care facility accounting and reporting system.

APPENDIX F

(b) Requests for modifications to the accounting and reporting systems as set forth by the Manual shall be filed as provided under Section 97050.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128760, Health and Safety Code.

97030. Failure to Meet Accounting Requirements.

(a) If the Office determines either by routine desk audit, on-site audit, or other means that a health facility is not substantially using on a day-to-day basis in its books and records the system of accounting prescribed by this Article, considering all modifications granted by the Office pursuant to Section 97050 and the special accounting provisions provided to health facilities by this Chapter and the Act, then the health facility shall be considered to be out of compliance with the prescribed system of accounting. If such a determination is made, the Office shall begin the following process:

(1) The Office shall notify the licensee at the mailing address of the health facility of the determination of noncompliance and the licensee shall have 90 days in which to file the following in writing with the Office:

APPENDIX F

(A) A copy of the health facility's current Chart of Accounts with account codes and titles certified by an official of the facility that it is the Chart of Accounts that is used on a day-to-day basis by the health facility and

(B) A detailed plan of action for the health facility to come into full compliance with the Office's specified system of accounting, including the planned date of implementation.

(2) The Office shall have 30 days from receipt of the Chart of Accounts and the plan of action required in (a)(1)(A) and (B) of this Section in which to review and respond in writing to the licensee regarding acceptance or rejection of the filed Chart of Accounts and plan of action.

(3) If the proposed plan of action is not approved by the Office, then the licensee shall be notified at the mailing address of the health facility that the licensee has a maximum of 30 days in which to file a revised plan of action.

(4) The Office shall have 30 days from receipt of the revised plan of action in which to review and respond in writing to the licensee regarding the revised plan's approval. With approval, the Office shall include a modification consistent with the approved plan of action.

(5) If the licensee fails to meet either of the deadlines established in (a)(1) or (a)(3), then the licensee shall be liable for a civil penalty, to be assessed and recovered in a civil action brought in the name of the people of the State of California by the Office, of one hundred dollars ($100) a day for each day either deadline is missed. For each determination of non-compliance described in this subsection, the total amount the health facility can be penalized is not to exceed five thousand dollars ($5,000). Within fifteen days after a penalty begins to accrue, the Office shall notify the licensee at the mailing address of the health facility of the penalty accrual and potential liability. The notification will include the licensee's right to appeal the penalty pursuant to Section 97052.

(b) After a health facility has been determined to be non-compliant and has failed to develop an approved plan of action to implement the prescribed system of accounting, the health facility shall be liable for a penalty of five thousand dollars ($5,000) each time the health facility files a report pursuant to either Section 128735(a) through (e) or Section 128740 of the Health and Safety Code. Within fifteen days after each penalty is determined, the Office shall notify the licensee at the mailing address of the health facility of the potential liability. The notification will include the licensee's right to appeal the penalty pursuant to Section 97052.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128735, 128740, 128760, and 128770, Health and Safety Code.

APPENDIX F

APPENDIX F

Article 3. Reporting Requirements

97040. Required Annual Reports.

(a) The licensee of each health facility, shall submit the following reports, except as provided in Section 97044, to the Office within four months after the end of each reporting period:

(1) A balance sheet for the unrestricted (general) funds.

(2) A balance sheet for the restricted funds.

(3) A statement of changes in equity (fund balances) for both unrestricted and restricted funds.

(4) A statement of income and expense.

(5) A statement of cash flows for the unrestricted funds.

(6) A cost finding report.

(7) A detailed statistical report.

(8) That data required for Medi-Cal cost reimbursement pursuant to Section 14170 of the Welfare and Institutions Code (skilled nursing, intermediate care, and congregate living health facilities only).

(9) A statement detailing patient revenue by payor and revenue center except, that hospitals authorized to report as a group pursuant to subdivision (d) of Section 128760 of the Health and Safety Code are not required to report by revenue center.

(10) And such other reports and worksheets as the Office enacts through the regulation process to constitute accurate and sufficiently detailed statistical reports and to enable proper completion of the above reports as set forth in the Office's "Accounting and Reporting Manual for California Hospitals," as specified in Section 97018, and the Office's "Accounting and Reporting Manual for California Long-term Care Facilities," as specified in Section 97019.

(b) A reporting period ends:

(1) at the close of the health facility's annual accounting period (fiscal year),

(2) on the last day of patient care when the health facility no longer accepts patients,

APPENDIX F

(3) on the last day of patient care at the old facility when the health facility closes to relocate to a new facility,

(4) on the last day of licensure of the entity relinquishing the license when there is a change in licensee, or

(5) on the last day of patient care when the license is placed in suspense.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735 and 128740, Health and Safety Code.

97041. Report Procedure.

(a) Health facilities shall report to the Office on forms or other media prescribed by the Office.

(1) Effective for reporting periods ending on or after June 30, 1994, health facilities shall file the annual reports required by subsections (a) through (e) of Section 128735, Health and Safety Code, with the Office in a standard electronic format as approved by the Office pursuant to Subsection (4). Health facilities may file requests for modifications to this reporting requirement, as provided under Section 97050, where meeting this requirement would not be cost-effective for the facility.

(2) Effective for reporting periods ending on or after March 31, 1994, hospitals shall file the quarterly reports required by Section 128740, Health and Safety Code, with the Office in a standard electronic format using the electronic reporting program (Hospital Quarterly Reporting System software, Version 1.1) provided by the Office. Hospitals may file requests for modifications to this reporting requirement, as provided under Section 97050, where meeting this requirement would not be cost-effective for the hospital.

(3) To meet the requirement of subsection (1), health facilities shall use a program approved pursuant to subsection (4), which can be either a third-party program or their own program. Health facilities intending to use a third-party program are not required to notify the Office of that intent. The Office shall notify all health facilities and third parties with Office-approved electronic reporting programs of any change in the electronic reporting requirements. The Office shall maintain and make available a list of all programs approved pursuant to subsection (4).

(4) Programs to be used for filing reports in a standard electronic format pursuant to subsection (1) must be approved by the Office in advance and must meet the Office's specifications for electronic reporting, including dial-up via personal computer and personal computer diskettes. To be approved,

APPENDIX F

electronic reporting programs must be able to apply Office-specified edits to the data being reported and must be able to produce a standardized output file that meets the Office's

specified electronic formats. Specifications for submitting hospital annual reports in a standard electronic format shall be provided by the Office upon request and shall include file and record formats, editing criteria, and test case requirements as published by the Office on November 19, 1992 in the "Instructions and Specifications for Submission of the California Hospital Disclosure Report on Personal Computer Diskette," and herein incorporated by reference in its entirety. Specifications for submitting LTC facility annual reports in a standard electronic format shall be provided by the Office upon request and shall include file and record formats, editing criteria, and test case requirements, as published by the Office on October 30, 1992 in the "Instructions and Specifications for Submission of the California Long-term Care Facility Integrated Disclosure & Medi-Cal Cost Report on 5 1/4" or 3 " IBM PC Compatible Diskette," and herein incorporated by reference in its entirety. To obtain approval for an electronic reporting program, a request, together with the Office's specified test case and a signed statement certifying that the program includes all Office-specified edits, must be filed with the Office at 818 K Street, Room 400, Sacramento, CA 95814, at least 90 days prior to the end of the reporting period to which the program applies. The Office shall review the test case and respond within 60 days by either approving or disapproving the request. The Office may limit the approval of the electronic reporting program to a specified period of time or reporting period(s). If disapproved, the Office shall set forth the basis for a denial. The Office may seek additional information from the requestor in evaluating the request. Changes to the Office's electronic reporting specifications may require the programs used for filing reports in a standard electronic format to be re-approved.

(b) The Office shall develop forms and instructions related to their use, and related specifications for filing reports in an electronic format, and make such administrative revisions to the above items as may be necessary to assure uniform and appropriate reporting.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128680, 128730, 128735 and 128740, Health and Safety Code.

97042. Comparative Reports.

Each health facility, except for new health facilities, shall include prior year comparative figures when reporting balance sheet - unrestricted funds, balance sheet - restricted funds, statement of cash flows - unrestricted funds, and statement of income and expense.

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

97043. Form of Authentication.

Each health facility report as specified by Sections 128735 (a) through (e) and Section 128740 of the

APPENDIX F

Health and Safety Code will be accompanied by a statement of authentication signed by a

duly authorized official of the health facility that certifies under penalty of perjury that, as applicable, the Office of Statewide Health Planning and Development's accounting and reporting system as set forth in either the Office's "Accounting and Reporting Manual for California Hospitals" or "Accounting and Reporting Manual for California Long-term Care Facilities" has been implemented by the health facility; that the data in the accompanying report are based on the appropriate system; and that to the best of the official's knowledge and information, each statement and amount in the accompanying report is believed to be true and correct.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, 128740 and 128760, Health and Safety Code; and
Section 14107.4, Welfare and Institutions Code.

97044. Exceptions to Required Reports.

County hospitals and State health facilities not operating under an enterprise system of accounting are not required to submit balance sheet statements, statement of changes in equity, or a statement of cash flows. However, all County and State health facilities are encouraged to move toward full compliance with all regulatory reporting requirements.

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

97045. Failure to File Required Reports.

Any health facility which does not file with the Office any report completed as required by this Article or by Article 8 is liable for a civil penalty of one hundred dollars ($100) a day to be assessed and recovered in a civil action brought in the name of the people of the State of California by the Office for each day the filing of such report with the Office is delayed, considering all approved extensions of the due date as provided in Section 97051 or in Section 97214. Assessed penalties may be appealed pursuant to Section 97052. Within fifteen days after the date the reports are due, the Office shall notify the health facility of reports not yet received, the amount of liability, and potential future liability for failure to file said reports when due.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128770, Health and Safety Code.

APPENDIX F

Article 4. Modification, Extension, and Appeal Processes

97050. Request for Modifications to Approved Accounting and Reporting Systems.

(a) To obtain modifications to the uniform accounting and reporting systems specified by Sections 97017, 97018, and 97019, including modifications to the account coding structure, health facilities must file a written request for modification with the Office. Health facilities must have an Office-approved modification prior to implementation of any change to the applicable uniform accounting system. Modification requests shall specify the precise changes being requested and the reason(s) the changes are needed. Requests from health facilities for modification to the applicable uniform accounting system, including requests to use an alternate coding scheme, shall be accompanied by (1) a cross reference between the facility's proposed account codes and titles, and the account codes and titles in the applicable accounting and reporting manual and (2) the facility's account definitions. The Office shall either approve or disapprove requests for modification within 60 days of the date the request was filed with the Office by the health facility, or the request shall be considered approved as submitted. However, if additional information is required from the health facility to evaluate the request, the Office shall have 30 days from the receipt of the additional information to approve or disapprove the request. The Office may also seek additional information from other appropriate sources to evaluate the request. Approved requests for systems modifications are subject to annual review and renewal by the Office.

(b) The Office shall grant modifications, upon written application, to licensed health facilities that are an integral part of a residential care complex to permit accounting and reporting for assets, liabilities, and equity for the entire residential care complex rather than require separate accounting for health care related assets, liabilities, and equity. Requests for modifications under this paragraph shall be submitted prior to the start of the accounting period to which the modifications are to apply and shall specify the proposed balance sheet account related modifications.

(c) The Office may grant modifications, upon written request, to licensees operating and maintaining more than one physical plant on separate premises under a single consolidated hospital license, issued pursuant to Health and Safety Code Section 1250.8, to file separate annual disclosure reports and quarterly financial and utilization reports for each location. The Office may also grant modifications, upon written request, to licensees of hospitals to file annual disclosure reports and quarterly financial and utilization reports for their mental health or rehabilitation care operations separately from the rest of the hospital operations. Licensees granted modifications under this paragraph shall be responsible for all regulatory requirements for each separate report. Separate extension requests, filed under the provisions of Section 97051, shall be required for each report, and penalties, assessed pursuant to Section 97045, shall be assessed on each delinquent report.

(d) In determining what modifications will be granted to health facilities under (a) or (c), the Office may take into account, but not be limited to the following factors:

(1) The data reported are comparable to data reported from other health facilities to the maximum extent feasible as determined by the Office;

(2) The report substantially complies with the purposes of the Health Data and Advisory Council Consolidation Act;

(3) The facility has considered and has a plan for the eventual or gradual implementation of the general accounting and reporting systems prescribed by the Office; and

(4) The burden on the health facility to report otherwise required data is sufficiently great that the cost to the health facility of preparing these data would outweigh the benefit to the people of the State of California.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128760, Health and Safety Code.

97051. Requests for Extension Time to File Required Reports.

Any licensee of a health facility may file with the Office requests for reasonable extensions of time to file any or all of the reports required pursuant to subdivisions (a) through (e) of Section 128735, Section 128740, or Section 128755, Health and Safety Code. Licensees of health facilities are encouraged to file extension requests as soon as it is apparent that the required reports will not be completed for submission on or before their due date. The requests for extension shall be supported by justification which may provide good and sufficient cause for the approval of the extension requests. To provide the Office a basis to judge good and sufficient cause, the letter of justification shall include a factual statement indicating (1) the actions taken by the health facility to produce the disclosure reports by the required deadline, (2) those factors which prevent completion of the reports by the deadline, and (3) those actions and the time (days) needed to accommodate those factors.

The Office shall respond within 10 calendar days of receipt of the request by either granting what the Office determines to be a reasonable extension or disapproving the request. If disapproved, the Office shall set forth the basis for a denial in a notice sent by certified mail to the health facility. The Office may seek additional information from the requesting health facility. The Office may grant extensions but not to exceed an accumulated total, for all extensions and corrections, of 90 days for annual reports required by Section 97040 and 30 days for quarterly reports required by Health and Safety Code

APPENDIX F

Section 128740. A health facility which wishes to contest any decision of the Office shall have the right to appeal in accordance with the provisions of Section 97052.

The civil penalty of one hundred dollars ($100) a day, provided for in Section 97045, shall commence the day after the report due date notwithstanding the filing of a petition to review the Office's denial of a request for an extension of time in which to file required reports or the filing of a request for an extension of time in which to file required reports.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128755 and 128770, Health and Safety Code.

97052. Appeal Procedure.

(a) Any health facility affected by any determination made under the Act by the Office may appeal the decision. This appeal shall be filed with the Office within 15 business days after the date the notice of the decision is received by the health facility and shall specifically describe the matters which are disputed by the petitioner.

(b) A hearing on an appeal shall, at the discretion of the Director, be held before any one of the following:

(1) An employee of the Office appointed by the Director to act as hearing officer.

(2) A hearing officer employed by the Office of Administrative Hearings.

(3) A committee of the Commission chosen by the chairperson for this purpose.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128775, Health and Safety Code.

97053. Conduct of Hearing.

(a) The hearing, when conducted by an employee of the Office appointed by the Director to serve as hearing officer or by a committee of the Commission, shall not be conducted according to technical rules relating to evidence and witnesses. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs.

(b) When the hearing is conducted by an employee of the Office or by a committee of the Commission, the hearing shall be recorded by a tape recording, unless the appellant agrees to provide a certified shorthand reporter at the appellant's expense. If the appellant provides a certified shorthand

APPENDIX F

reporter, the original of the transcript shall be provided directly to the Office.

(c) A copy of the tape recording or of the transcript, if made, shall be available to any person so requesting who has deposited with the Office an amount of money which the Director has determined to be sufficient to cover the costs of the copy of the tape recording or transcript.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128775, Health and Safety Code.

97054. Decision on Appeal.

(a) The employee, hearing officer, or committee shall prepare a recommended decision which includes findings of fact and conclusions of law.

(b) This proposed decision shall be presented to the Office for its consideration.

(c) The Office may adopt the proposed decision, or reject it and decide the matter as described in paragraph 1 below.

(1) If the Office does not adopt the proposed decision as presented, it will furnish a Notice of Rejection of Proposed Decision along with a copy of the proposed decision to appellant and, if applicable, appellant's authorized representative. The Office will provide appellant the opportunity to present written arguments to the Office. The decision of the Office will be based on the record, including the hearing record, and such additional information as is provided by the appellant.

(d) The decision of the Office shall be in writing. It shall be made within 60 calendar days after the conclusion of the hearing and shall be final.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128775, Health and Safety Code.

Article 5. Collection of Special Fees

97062. Notice of Assessment.

The Office shall mail a notice of special fee assessment and a remittance advice form to each health facility immediately after the assessment rate is set by the Office. The remittance advice form shall be completed by each health facility and returned to the Office with full payment of the special fee amount.

Authority: Sections 127150 and 128810, Health and Safety Code.

APPENDIX F

Reference: Section 127280, Health and Safety Code.

APPENDIX F

97063. Basis of Assessment.

The basis of assessment is the total gross operating expenses obtained from the disclosure reports filed for the report period which ended on or before June 30 of the previous calendar year, as more particularly described in Section 97005(h).

Authority: Sections 127150 and 128810, Health and Safety Code.
Reference: Section 127280, Health and Safety Code.

97064. Exceptions to the Basis of Assessment.

(a) New health facilities which have no fiscal years ending on or before June 30 of the preceding calendar year are not liable for the special fee.

(b) New health facilities which have a fiscal year ending during the twelve month period preceding and including June 30 of the previous calendar year but which is less than 12 months, shall be liable for the special fee based on the gross operating expenses of the partial fiscal year.

(c) If a health facility does not have a fiscal year ending during the twelve month period preceding and including June 30 of the previous calendar year due to a change in licensee, the special fee shall be based on the gross operating expenses of the previous licensee's last completed fiscal year expanded to 12 months if applicable. If the gross operating expenses of the previous licensee's last fiscal year are not available to the current licensee, the special fee shall be the last special fee paid by the previous licensee plus ten percent. The Office shall furnish the amount of the last special fee paid by the previous licensee upon request of the affected health facility.

(d) If a health facility does not have a complete fiscal year ending during the twelve month period preceding and including June 30 of the previous calendar year due to a change in licensee, the special fee shall be based on the gross operating expenses of the partial fiscal year expanded to 12 months. The partial fiscal year is those months from the start of health facility operations under the new licensee to the end of the fiscal year.

(e) If a health facility does not have a complete fiscal year ending during the 12 month period preceding and including June 30 of the previous calendar year due to a change in fiscal year, the special fee shall be based on the gross operating expenses of the partial fiscal year expanded to 12 months. The partial fiscal year is those months from the close of the last complete fiscal year to the end of the new partial fiscal year.

APPENDIX F

(f) The Office shall determine the basis of assessment for special fee amounts due from health facilities in those circumstances not specifically covered above.

Authority: Section 127150 and 128810, Health and Safety Code.
Reference: Section 127280, Health and Safety Code.

97065. Delinquent Special Fees.

To enforce payment of delinquent special fees, the Office shall notify the State Department of Health Services not to issue a license and not to renew the existing license of the delinquent health facility until the special fees have been paid, pursuant to Section 127280, Health and Safety Code. A copy of the Office notice to the State Department of Health Services shall be sent to the delinquent health facility.

Authority: Sections 127150 and 128810, Health and Safety Code; and Section 11152, Government Code.
Reference: Section 127280, Health and Safety Code.

Article 6. Public Availability of Disclosure Materials

97110. Place and Time of Availability.

Copies of available disclosure materials may be inspected by and copied for any person upon request during regular business hours at the Office of Statewide Health Planning and Development in Sacramento.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128680 and 128765, Health and Safety Code.

97115. Manner of Requesting Disclosure Materials.

(a) Requests for disclosure materials shall be filed in writing with the Office. A request shall contain sufficient information to enable the Office to determine what specific materials are being requested.

(b) No disclosure materials shall be provided, except as may be specifically authorized by the Director, without prior payment of a fee sufficient to cover costs of production and provision of the materials.

Authority: Section 128810, Health and Safety Code.

APPENDIX F

Reference: Sections 128680 and 128765, Health and Safety Code.

APPENDIX F

97125. Protection of Records.

(a) No person may, without permission of the Office, remove from the Office any disclosure materials made available for inspection or copying.

(b) Only photocopies of the original disclosure materials shall be available for public inspection except as authorized by the Director.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128680 and 128765, Health and Safety Code.

Article 7. (Reserved)

Article 8. Discharge Data Reporting Requirements

97210. Notice of Change in Hospital Reporting Period, Contact Person, Method of Submission or Designated Abstractor.

(a) Each hospital shall notify the Office's Discharge Data Program in writing within 30 days after any change in the person designated as the patient discharge contact person or in the telephone number of the contact person.

(b) Each hospital shall notify the Office's Discharge Data Program in writing within 30 days after any change in method of submission (Office abstracting forms, magnetic computer tapes or diskettes) or designated abstractor or designated agent for the purpose of submitting the hospital's discharge data reports. If there is a change in designated agent, the hospital or its new agent must comply with Section 97215. A hospital may submit its own discharge data directly to the Office's Discharge Data Program, or it may designate an agent for this purpose.

(c) Each hospital beginning or resuming operations, whether in a newly constructed facility or in an existing facility, shall notify the Office's Discharge Data Program within 30 days after its first day of operation of its: abstractor (if it chooses to use one), designated agent for the purpose of submitting the hospital's discharge data report (if it chooses not to submit its report directly), method of submission (Office abstracting forms, magnetic computer tapes or diskettes), contact person, and telephone number of contact person. The hospital shall be provided a unique identification number that it can report pursuant to Section 97239. Pursuant to Section 97215, the hospital, if it chooses to designate itself to

APPENDIX F

submit its discharge data reports, and its method of submission is not paper abstracting forms, shall submit a set of test data that is in compliance with the required format. Pursuant to Section 97215, any agent the hospital designates to submit

APPENDIX F

discharge data on its behalf must have submitted a test set of data that is in compliance with the required format, prior to the due date of the hospital's first report period.

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

97211. Reporting Periods and Due Dates.

(a) The prescribed reporting period is calendar semiannual, which means that there are two report periods each year, consisting of discharges occurring January 1 through June 30, and discharges occurring July 1 through December 31. The prescribed due dates are six months after the end of each report period; thus, the due date for the January 1 through June 30 report period is December 31 of the same year, and the due date for the July 1 through December 31 report period is June 30 of the following year.

(b) Where there has been a change in the licensee of a hospital, the effective date of the change in licensee shall constitute the start of the report period for the new licensee, and this first report period shall end on June 30 or December 31, whichever occurs first. The final day of the report period for the previous licensee shall be the last day their licensure was effective, and the due date for the report shall be six months after the final day of this report period.

(c) Reports shall be filed, as defined in Section 97005, by the date the report is due. Where a hospital has been granted an extension, pursuant to Section 97241, the ending date of the extension shall constitute the new due date for that report.

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

97212. Definitions, as used in this Article.

This section, as adopted October 14, 1993, applies to discharges prior to and including December 31, 1996. For Section 97212 applicable to discharges occurring on and after January 1, 1997, see below.

(a) California Hospital Discharge Data Set. The California Hospital Discharge Data Set consists of the seventeen data elements of the hospital discharge abstract data record, as specified in subsection (g) of Section 443.31 of the Health and Safety Code.

(b) Designated Agent. Examples of possible designated agents include the hospital's abstractor, a

APPENDIX F

data processing firm, or the data processing unit in the corporate office of the hospital.

APPENDIX F

(c) Discharge. A discharge is defined as a newborn or a person who was formally admitted to a hospital as an inpatient for observation, diagnosis, or treatment, with the expectation of remaining overnight or longer, and who is discharged under one of the following circumstances:

(1) is formally discharged from the care of the hospital and leaves the hospital,

(2) transfers within the hospital from one level of care to another level of care, as defined in Subsection (g) of Section 97212, or

(3) has died.

(d) DRG. Diagnosis Related Groups is a classification scheme with which to categorize patients according to clinical coherence and expected resource intensity, as indicated by their diagnoses, procedures, age, sex, and disposition, and was established and is revised annually by the U.S. Health Care Financing Administration.

(e) DSM-III-R. Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised, as produced by and available from the American Psychiatric Association, Washington, D.C.

(f) ICD-9-CM. The International Classification of Diseases, 9th Revision, Clinical Modification, as 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 Health Care Financing Administration, the National Center for Health Statistics, and the American Health Information Management Association).

(g) Level of Care. Level of care is defined as one of the following:

(1) Skilled nursing/intermediate care. Skilled nursing/intermediate care is inpatient care that is provided to inpatients occupying beds appearing on the hospital's license in the classifications of skilled nursing or intermediate care, as defined by Subsection (b), (c), or (d), 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 which are being used to provide skilled nursing/intermediate care to those inpatients in an approved swing bed program.

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

APPENDIX F

(3) Psychiatric care. Psychiatric care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license as acute psychiatric beds, as defined by Subsection (e) of Section 1250.1 of the Health and Safety Code.

APPENDIX F

(4) Acute care. Acute care means all other types of inpatient care provided to inpatients occupying all other types of licensed beds in a hospital.

(h) Licensee. Licensee means an entity that has been issued a license to operate a hospital, as defined in Section 443.21 (c) of the Health and Safety Code.

(i) Record. A record is defined as the set of seventeen data elements of the "hospital discharge abstract data record" as specified in subsection (g) of Section 443.31 of the Health and Safety Code, for one patient.

(j) Report. A report is defined as the collection of all records submitted by a hospital for a semiannual reporting period, or for a shorter period pursuant to Section 97211(b).

Authority: Section 443.45, Health and Safety Code.
Reference: Sections 443.21, 443.31, 1250, and 1250.1, Health and Safety Code.

97212. Definitions, as used in this Article.

This section, as amended effective August 14, 1996, applies to discharges on and after January 1, 1997. For Section 97212 applicable to discharges occurring prior to and including December 31, 1996, see above.

(a) California Hospital Discharge Data Set. The California Hospital Discharge Data Set consists of the data elements of the hospital discharge abstract data record, as specified in subsection (g) of Section 128735 of the Health and Safety Code.

(b) Designated Agent. Examples of possible designated agents include the hospital's abstractor, a data processing firm, or the data processing unit in the corporate office of the hospital.

(c) Discharge. A discharge is defined as a newborn or a person who was formally admitted to a hospital as an inpatient for observation, diagnosis, or treatment, with the expectation of remaining overnight or longer, and who is discharged under one of the following circumstances:

(1) is formally discharged from the care of the hospital and leaves the hospital,

(2) transfers within the hospital from one type of care to another type of care, as defined in Subsection (g) of Section 97212, or

APPENDIX F

(3) has died.

(d) DRG. Diagnosis Related Groups is a classification scheme with which to categorize patients according to clinical coherence and expected resource intensity, as indicated by their

APPENDIX F

diagnoses, procedures, age, sex, and disposition, and was established and is revised annually by the U.S. Health Care Financing Administration.

(e) DSM-III-R. Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised, as produced by and available from the American Psychiatric Association, Washington, D.C.

(f) ICD-9-CM. The International Classification of Diseases, 9th Revision, Clinical Modification, as 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 Health Care Financing Administration, the National Center for Health Statistics, and the American Health Information Management Association).

(g) Type of Care. Type of care 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 Subsection (a)(2), (a)(3), or (a)(4), 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 which 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 in Subsection (a)(1) 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 of Section 70595 of Title 22, 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 in Subsection (a)(5) of Section 1250.1 of the Health and Safety Code, and psychiatric health facility, as defined in Subsection (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 in Subsection (a)(7) of Section 1250.1 and Subsections (a), (c), or (d) of Section 1250.3 of the Health and Safety Code.

(5) Acute care. Acute care, defined in Subsection (a)(1) 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

APPENDIX F

beds in a hospital, other than specified in Subsections (g)(1), (g)(2), (g)(3), and (g)(4) of Section 97212 of Title 22, California Code of Regulations.

APPENDIX F

(h) Licensee. Licensee means an entity that has been issued a license to operate a hospital, as defined in Section 128700(c) of the Health and Safety Code.

(i) Record. A record is defined as the set of data elements of the "hospital discharge abstract data record" as specified in subsection (g) of Section 128735 of the Health and Safety Code, for one patient.

(j) Report. A report is defined as the collection of all records submitted by a hospital for a semiannual reporting period, or for a shorter period pursuant to Section 97211(b).

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

97213. Required Reporting.

This section, as adopted October 14, 1993, applies to discharges prior to and including December 31, 1996. For Section 97213 applicable to discharges occurring on and after January 1, 1997, see below.

(a) Each hospital shall submit the seventeen data elements of the hospital discharge abstract data record, as specified in subdivision (g) of Section 443.31 of the Health and Safety Code, for each inpatient discharged during the semiannual report period, according to the format specified in Section 97215 and by the dates specified in Section 97211.

(b) For discharges on or after January 1, 1995, a hospital shall separately identify records of patients being discharged from the skilled nursing/intermediate care level of care, as defined in Subsection (g)(1) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on paper abstracting forms (OSHPD 1370), the hospital shall identify these records by placing them in a separate collection of abstracting forms. Each separate collection of abstracting forms shall have an accompanying transmittal form, pursuant to Section 97214, which shall identify the collection of abstracting forms as being from the skilled nursing/intermediate care level of care. If submitted on computer diskette, the hospital shall identify these records by placing them on a separate diskette, and identifying their level of care on the accompanying transmittal form submitted pursuant to Section 97214. If submitted on computer tape (reel or cartridge), the hospital shall identify these records by recording a "3" in the first position on each of these records.

(c) For discharges on or after January 1, 1995, a hospital shall separately identify records of patients being discharged from the rehabilitation level of care, as defined in Subsection (g)(2) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on paper abstracting forms (OSHPD 1370), the hospital shall identify these records by placing

APPENDIX F

them in a separate collection of abstracting forms. Each separate

collection of abstracting forms shall have an accompanying transmittal form, pursuant to Section 97214, which shall identify the collection of abstracting forms as being from the rehabilitation level of care. If submitted on computer diskette, the hospital shall identify these records by placing them in a separate diskette, and identifying their level of care on the accompanying transmittal form. If submitted on computer tape (reel or cartridge), the hospital shall identify these records by recording a "6" in the first position on each of these records.

(d) For discharges on or after January 1, 1995, hospitals submitting records on computer tape (reel or cartridge) shall put a "1" in the first position on each record not identified with a "3" (pursuant to section 97213(b)) or a "6" (pursuant to section 97213(c)). Hospitals submitting discharge records on computer tape may combine all levels of care on the same tape.

(e) A hospital operating under a consolidated license may submit its discharge data report in separate sets of records that relate to separate physical plants.

(f) If a hospital submits its report in separate sets of records, the compilation of those sets must include all discharge records from all levels of care and from all physical plants on that hospital's license. The complete compilation of sets of records for a hospital comprises that hospital's report for purposes of this Article.

Authority: Section 443.45, Health and Safety Code.
Reference: Section 443.31, Health and Safety Code.

97213. Required Reporting.

This section, as amended effective August 14, 1996, applies to discharges on and after January 1, 1997. For Section 97213 applicable to discharges occurring prior to and including December 31, 1996, see above.

(a) Each hospital shall submit the data elements of the hospital discharge abstract data record, as specified in subdivision (g) of Section 128735 of the Health and Safety Code, for each inpatient discharged during the semiannual report period, according to the format specified in Section 97215 and by the dates specified in Section 97211.

(b) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the acute care type of care, as defined in Subsection (g)(5) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on paper abstracting forms (OSHPD 1370), the hospital shall identify these records by recording a "1" in the space provided. If submitted on computer tape (reel or cartridge) or diskette, the

hospital shall identify these records by recording a "1" in the first position on each of these records.

APPENDIX F

(c) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the skilled nursing/intermediate care type of care, as defined in Subsection (g)(1) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on paper abstracting forms (OSHPD 1370), the hospital shall identify these records by recording a "3" in the space provided. If submitted on computer tape (reel or cartridge) or diskette, the hospital shall identify these records by recording a "3" in the first position on each of these records.

(d) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the psychiatric care type of care, as defined in Subsection (g)(3) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on paper abstracting forms (OSHPD 1370), the hospital shall identify these records by recording a "4" in the space provided. If submitted on computer tape (reel or cartridge) or diskette, the hospital shall identify these records by recording a "4" in the first position on each of these records.

(e) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the chemical dependency recovery care type of care, as defined in Subsection (g)(4) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on paper abstracting forms (OSHPD 1370), the hospital shall identify these records by recording a "5" in the space provided. If submitted on computer tape (reel or cartridge) or diskette, the hospital shall identify these records by recording a "5" in the first position on each of these records.

(f) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the physical rehabilitation care type of care, as defined in Subsection (g)(2) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on paper abstracting forms (OSHPD 1370), the hospital shall identify these records by recording a "6" in the space provided. If submitted on computer tape (reel or cartridge) or diskette, the hospital shall identify these records by recording a "6" in the first position on each of these records.

(g) Hospitals submitting discharge records on Manual Abstract Reporting Forms (OSHPD 1370) or diskette shall combine all types of care using one transmittal form. Hospitals submitting discharge records on computer tape (reel or cartridge) shall combine all types of care on the same tape.

(h) A hospital operating under a consolidated license may submit its discharge data report in separate sets of records that relate to separate physical plants.

(i) If a hospital operating under a consolidated license submits its report in separate sets of records, the

APPENDIX F

compilation of those sets must include all discharge records from all types of care and

APPENDIX F

from all physical plants on that hospital's license. The complete compilation of sets of records for a hospital comprises that hospital's report for purposes of this Article.

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

97214. Form of Authentication.

This section, as adopted October 14, 1993, applies to discharges prior to and including December 31, 1996. For Section 97214 applicable to discharges occurring on and after January 1, 1997, see below.

(a) Hospitals submitting their hospital discharge abstract data records using the (paper) Manual Abstract Reporting Form (OSHPD 1370) must submit, with each separate collection of discharge abstract data forms, a completed Individual Hospital Transmittal Form (OSHPD 1370.1), including the following information: the hospital name, hospital identification number as described in Section 97239, the report period beginning and ending dates, the number of records, and the following statement of certification, to be signed by the hospital administrator or his/her designee:

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information the accompanying discharge abstract data records are true and correct, and that the definitions of the data elements required by subdivision (g) of Section 443.31 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: ______________ ________________________________
(Name of hospital)

By: ___________________________

Title: ___________________________

Address: ______________________

A hospital which uses the Individual Hospital Transmittal Form (OSHPD 1370.1) is not required to submit a separate Discharge Data Certification Form (OSHPD 1370.3).

APPENDIX F

(b) Hospitals submitting their hospital discharge abstract data records using computer media, rather than the Manual Abstract Reporting Form (OSHPD 1370), must submit with each computer tape or diskette a completed Individual Hospital Transmittal Form (OSHPD 1370.1), including the following information: the hospital name, hospital identification number (as described in Section 97239), the report period beginning and ending dates, the number of records, tape specifications (if a tape), and the signed statement of certification as in Section 97214(a). Hospitals submitting more than one report on a single tape shall specify on the Individual Hospital Transmittal Form (OSHPD 1370.1), separately for each report on the tape, the hospital identification number, the report period beginning and ending dates, and the number of records.

(c) Hospitals that designate an agent to submit their hospital discharge abstract data records must submit a Discharge Data Certification Form (OSHPD 1370.3) to the Office's Discharge Data Program. This form shall be mailed after the end of each report period, and before that corresponding report period's due date. The certification must cover the same reporting period as the data submitted by the designated agent. This form, which contains the following statement of certification, shall be signed by the hospital administrator or his/her designee:

APPENDIX F

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information the discharge abstract data records submitted to (name of my hospital's designated agent) for the period from (starting date) to (ending date) are true and correct, and that the definitions of the data elements required by subdivision (g) of Section 443.31 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: ______________ ________________________________
(Name of hospital)

By: ___________________________

Title: ___________________________

Address: ______________________

(d) Agents who have been designated by a hospital through the Discharge Data Certification Form (OSHPD 1370.3) to submit that hospital's discharge abstract data records must submit with each computer tape or diskette a completed Agent's Transmittal Form (OSHPD 1370.2), including the following information clearly indicated: tape specifications (if a tape), hospital name, hospital identification number, the report period beginning and ending dates, and the number of records. If the computer media contains more than 13 reports, page two of the Agent's Transmittal Form (OSHPD 1370.2) shall be completed and attached to page one.

Designated agents are not required to submit any certification forms.

APPENDIX F

(e) Any hospital or designated agent may obtain free copies of forms OSHPD 1370.1, 1370.2, and 1370.3 by contacting the Office's Discharge Data Program.

Authority: Section 443.45, Health and Safety Code.
Reference: Section 443.31, Health and Safety Code.

97214. Form of Authentication.

This section, as amended effective August 14, 1996, applies to discharges on and after January 1, 1997. For Section 97214 applicable to discharges occurring prior to and including December 31, 1996, see above.

(a) Hospitals submitting their hospital discharge abstract data records using the (paper) Manual Abstract Reporting Form (OSHPD 1370) must submit a completed Individual Hospital Transmittal Form (OSHPD 1370.1), including the following information: the hospital name, hospital identification number as described in Section 97239, the report period beginning and ending dates, the number of records, and the following statement of certification, to be signed by the hospital administrator or his/her designee:

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information, the accompanying discharge abstract data records are true and correct, and that the definitions of the data elements required by subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: ______________ ________________________________
(Name of hospital)

By: ___________________________

Title: ___________________________

Address: ______________________

A hospital which uses the Individual Hospital Transmittal Form (OSHPD 1370.1) is not required to submit a separate Discharge Data Certification Form (OSHPD 1370.3).

(b) Hospitals submitting their hospital discharge abstract data records using computer media, rather

APPENDIX F

than the Manual Abstract Reporting Form (OSHPD 1370), must submit with each computer tape (reel or cartridge) or diskette a completed Individual Hospital Transmittal Form

APPENDIX F

(OSHPD 1370.1), including the following information: the hospital name, hospital identification number (as described in Section 97239), the report period beginning and ending dates, the number of records, tape specifications (if a tape), and the signed statement of certification as in Section 97214(a).

(c) Hospitals that designate an agent to submit their hospital discharge abstract data records must submit a Discharge Data Certification Form (OSHPD 1370.3) to the Office's Discharge Data Program. This form shall be mailed after the end of each report period, and before that corresponding report period's due date. The certification must cover the same reporting period as the data submitted by the designated agent. This form, which contains the following statement of certification, shall be signed by the hospital administrator or his/her designee:

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information, the discharge abstract data records submitted to (name of my hospital's designated agent) for the period from (starting date) to (ending date) are true and correct, and that the definitions of the data elements required by subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: ______________ ________________________________
(Name of hospital)

By: ___________________________

Title: ___________________________

Address: ______________________

(d) Agents who have been designated by a hospital through the Discharge Data Certification Form (OSHPD 1370.3) to submit that hospital's discharge abstract data records must submit with each computer tape or diskette a completed Agent's Transmittal Form (OSHPD 1370.2), including the following information clearly indicated: tape specifications (if a tape), hospital name, hospital identification number, the report period beginning and ending dates, and the number of records. If the computer media contains more than 13 reports, page two of the Agent's Transmittal Form (OSHPD 1370.2) shall be completed and attached to page one.

Designated agents are not required to submit any certification forms.

APPENDIX F

(e) Any hospital or designated agent may obtain free copies of forms OSHPD 1370.1, 1370.2, and 1370.3 by contacting the Office's Discharge Data Program.

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

97215. Format.

Patient discharge data shall be reported to the Office's Discharge Data Program on either OSHPD Form 1370 (Manual Abstract Reporting Form) or on magnetic computer tapes (reel or cartridge) or diskettes. The version of Form 1370 to be used depends on the date of discharge: discharges occurring before January 1, 1995 shall use Form 1370 as revised July 1990; discharges January 1, 1995 through December 31, 1995 shall use Form 1370 as revised October 1993; discharges January 1, 1996 through December 31, 1996 shall use Form 1370 as revised May 1995; discharges on and after January 1, 1997 shall use Form 1370 as revised June 1996. The Office shall furnish each hospital using Form 1370 sufficient copies of the appropriate version in advance of the start of each reporting period.

The format and specifications for the computer tapes or diskettes depend on the date of discharge: computer tapes or diskettes containing discharges occurring before January 1, 1995 shall comply with the Office's standard format and specifications, as updated July 1990; computer tapes or diskettes containing discharges occurring January 1, 1995 through December 31, 1995 shall comply with the Office's standard format and specifications, as updated October 1993; discharges January 1, 1996 through December 31, 1996 shall comply with the Office's standard format and specifications as updated August 1995; discharges on and after January 1, 1997 shall comply with the Office's standard format and specifications as updated September 1, 1995. The Office shall furnish each hospital and designated agent a copy of the standard format and specifications before the start of the report period to which revisions apply. Additional copies may be obtained at no charge from the Office's Discharge Data Program.

Each hospital (or its agent, if it has designated one), whose discharge data is submitted on computer media, in whole or part, shall demonstrate its ability to comply with the standard format and specifications by submission of a test file of its data with which the Office can confirm compliance with the standard format and specifications.

Such a test file shall be submitted at least 60 days prior to the next report period due date by new hospitals or by existing hospitals after a change in any of the following: the Office's standard format and specifications, the hospital's computer system (or that of its designated agent), the computer media used by the hospital or its designated agent, the method of submittal (from

APPENDIX F

OSHPD Form 1370 to computer media), or the designated agent, unless the new designated agent has already submitted a test file that complied with the standard format and specifications.

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

97221. Definition of Data Element--Admission Date.

This section, as adopted October 14, 1993, applies to discharges prior to and including December 31, 1996. For Section 97221 applicable to discharges occurring on and after January 1, 1997, see below.

The patient's date of admission shall be reported in numeric form as follows: the 2-digit month, 2-digit day and final 2 digits of the year. The numeric form for days and months from 1 to 9 must have a zero as the first digit. For discharges representing a transfer of a patient from one level of care within the hospital to another level of care within the hospital, as defined in Subsection (g) of Section 97212 and reported pursuant to Section 97212, the admission date reported shall be the date the patient was transferred to the level of care being reported on this record.

Authority: Section 443.45, Health and Safety Code.
Reference: Section 443.31, Health and Safety Code.

97221. Definition of Data Element--Admission Date.

This section, as amended effective August 14, 1996, applies to discharges on and after January 1, 1997. For Section 97221 applicable to discharges occurring prior to and including December 31, 1996, see above.

The patient's date of admission shall be reported in numeric form as follows: the 2-digit month, 2-digit day and final 2 digits of the year. The numeric form for days and months from 1 to 9 must have a zero as the first digit. For discharges representing a transfer of a patient from one type of care within the hospital to another type of care within the hospital, as defined in Subsection (g) of Section 97212 and reported pursuant to Section 97212, the admission date reported shall be the date the patient was transferred to the type of care being reported on this record.

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

97222. Definition of Data Element--Source of Admission.

APPENDIX F

(a) Discharges occurring before January 1, 1995 shall have the source of admission defined as the physical site from which the patient was admitted or the area in the health facility where the

patient was located just prior to his or her admission as an inpatient, and reported as one of the following:

(1) Routine. Any ordinary admission through the admissions office or from the hospital-based Outpatient Department.

(2) Emergency Room. Any patient admitted as an inpatient after being treated or examined in the hospital-based Emergency Room.

(3) Short-Term Acute Care Hospital. Any patient transferred or referred from a short-term acute care hospital or from short-term care within the hospital to another level of care.

(4) Intermediate Care Facility (ICF). Any patient transferred or referred from an intermediate care facility (free standing or hospital-based) or from ICF care within the hospital to another level of care.

(5) Skilled Nursing Facility (SNF). Any patient transferred or referred from a skilled nursing facility (free-standing or hospital-based) or from SNF care within the hospital to another level of care.

(6) Other Facility. Any patient transferred or referred from a facility other than a short-term acute care hospital, intermediate care facility or skilled nursing facility.

(7) Home Health Service. Any patient transferred or referred from a licensed home health service program.

(8) Newborn. Babies born alive in the hospital.

(9) Other. Admission from a source other than mentioned above or unknown.

(b) Effective with discharges occurring January 1, 1995 through December 31, 1996, in order to describe the patient's source of admission, it is necessary to address three aspects of the source: first, the level of care being received by the patient prior to admittance, as indicated by the nature of the site from which the patient originated; second, the license under which the level of care was provided; and, third, the route by which the patient was admitted. One alternative shall be selected from the list following each of three aspects:

(1) Level of care being received by the patient prior to admittance, as indicated by the site from which the patient was admitted.

APPENDIX F

(A) Home. A patient admitted from the patient's home, the home of a relative or friend, or a vacation site, whether or not the patient was seen at an outpatient clinic or physician's office, or had been receiving home health services or hospice care at home.

(B) Residential Care Facility. A patient admitted from a facility in which the patient resides and which provides special assistance to its residents in activities of daily living, but which provides no organized health care.

(C) Ambulatory Surgery. A patient admitted after treatment or examination in an ambulatory surgery facility, whether hospital-based or a freestanding licensed ambulatory surgery clinic or certified ambulatory surgery center. Excludes outpatient clinics and physicians' offices not licensed and/or certified as an ambulatory surgery facility.

(D) Long Term Care. A patient admitted from skilled nursing care or intermediate care, whether freestanding or hospital-based, or from a Congregate Living Health Facility as defined in Health and Safety Code Section 1250(i).

(E) Acute Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care of a medical/surgical nature, such as in a perinatal, pediatric, intensive care, coronary care, burn, etc., unit of a hospital.

(F) Other Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care not of a medical/surgical nature, such as in a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit.

(G) Newborn. A baby born alive in this hospital.

(H) Prison, Jail. A patient admitted from a correctional institution.

(I) Other. A patient admitted from a source other than mentioned above. Includes patients admitted from: a VA hospital or a freestanding (not hospital-based) inpatient hospice facility.

(2) License under which the level of care was provided.

(A) This hospital. The Ambulatory Surgery, Long Term Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of this hospital. Includes all newborns.

(B) Another hospital. The Ambulatory Surgery, Long Term Care, Acute Hospital Care, or Other

APPENDIX F

Hospital Care from which the patient was admitted was operated as part of the license of some other hospital.

APPENDIX F

(C) Not a hospital. The site from which the patient was admitted was not operated under the license of a Hospital. Includes all patients admitted from Home, Residential Care, Prison/Jail, and Other sites. Includes patients admitted from Ambulatory Surgery or Long Term Care sites which were not operated under the authority of the license of any hospital. Excludes all patients admitted from Acute Hospital Care or Other Hospital Care.

(3) Route of admission.

(A) Your Emergency Room. Any patient admitted as an inpatient after being treated or examined in this hospital's emergency room. Excludes patients seen in the emergency room of some other hospital.

(B) Not Your Emergency Room. Any patient admitted as an inpatient without being treated or examined in this hospital's emergency room. Includes patients seen in the emergency room of some other hospital and patients not seen in any emergency room.

(c) Effective with discharges on January 1, 1997, in order to describe the patient's source of admission, it is necessary to address three aspects of the source: first, the site from which the patient originated; second, the licensure of the site from which the patient originated; and, third, the route by which the patient was admitted. One alternative shall be selected from the list following each of three aspects:

(1) The site from which the patient was admitted.

(A) Home. A patient admitted from the patient's home, the home of a relative or friend, or a vacation site, whether or not the patient was seen at an outpatient clinic or physician's office, or had been receiving home health services or hospice care at home.

(B) Residential Care Facility. A patient admitted from a facility in which the patient resides and which provides special assistance to its residents in activities of daily living, but which provides no organized health care.

(C) Ambulatory Surgery. A patient admitted after treatment or examination in an ambulatory surgery facility, whether hospital-based or a freestanding licensed ambulatory surgery clinic or certified ambulatory surgery center. Excludes outpatient clinics and physicians' offices not licensed and/or certified as an ambulatory surgery facility.

(D) Long Term Care. A patient admitted from skilled nursing care or intermediate care, whether

freestanding or hospital-based, or from a Congregate Living Health Facility as defined in Health and Safety Code Section 1250(i).

APPENDIX F

(E) Acute Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care of a medical/surgical nature, such as in a perinatal, pediatric, intensive care, coronary care, burn, etc., unit of a hospital.

(F) Other Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care not of a medical/surgical nature, such as in a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit.

(G) Newborn. A baby born alive in this hospital.

(H) Prison, Jail. A patient admitted from a correctional institution.

(I) Other. A patient admitted from a source other than mentioned above. Includes patients admitted from: a VA hospital or a freestanding (not hospital-based) inpatient hospice facility.

(2) Licensure of the Site.

(A) This hospital. The Ambulatory Surgery, Long Term Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of this hospital. Includes all newborns.

(B) Another hospital. The Ambulatory Surgery, Long Term Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of some other hospital.

(C) Not a hospital. The site from which the patient was admitted was not operated under the license of a Hospital. Includes all patients admitted from Home, Residential Care, Prison/Jail, and Other sites. Includes patients admitted from Ambulatory Surgery or Long Term Care sites which were not operated under the authority of the license of any hospital. Excludes all patients admitted from Acute Hospital Care or Other Hospital Care.

(3) Route of admission.

(A) Your Emergency Room. Any patient admitted as an inpatient after being treated or examined in this hospital's emergency room. Excludes patients seen in the emergency room of some other hospital.

(B) Not Your Emergency Room. Any patient admitted as an inpatient without being treated or examined in this hospital's emergency room. Includes patients seen in the emergency room of some other hospital and patients not seen in any emergency room.

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

97223. Definition of Data Element--Type of Admission.

(a) Discharges occurring before January 1, 1995 shall have the patient's type of admission reported using one of the following categories:

(1) Emergency. Immediate admission required for the alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical/psychiatric conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

(2) Urgent. A non-emergency admission where the patient is in need of medical/psychiatric attention and hospitalization as soon as possible.

(3) Elective. All routine admissions and admissions whose postponement would not endanger the life, limb and mental faculties of the patient.

(4) Newborn. Baby born alive in this hospital.

(5) Delivery. Patients admitted for delivery of a child with a principal diagnosis of delivery.

(6) Unknown. Nature of admission not known. Does not include still births.

(b) Effective with discharges on January 1, 1995, the patient's type of admission shall be reported using one of the following categories:

(1) Scheduled. Admission was arranged with the hospital at least 24 hours prior to the admission.

(2) Unscheduled. Admission was not arranged with the hospital at least 24 hours prior to the admission.

(3) Infant. An infant less than 24 hours old.

(4) Unknown. Nature of admission not known. Does not include stillbirths.

Authority: Section 443.45, Health and Safety Code.
Reference: Section 443.31, Health and Safety Code.

97224. Definition of Data Element--Discharge Date.

The patient's date of discharge shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the final 2 digits of the year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 443.45, Health and Safety Code.
Reference: Section 443.31, Health and Safety Code.

97225. Definition of Data Element - Principal Diagnosis and Whether the Condition was Present at Admission.

(a) 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 International Classification of Diseases, 9th Revision, Clinical Modification, U.S. Department of Health and Human Services, Washington, D.C. (ICD-9-CM), except that psychiatric diagnoses may be coded according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, American Psychiatric Association, Washington, D.C. (DSM IV), Axes I, II, and III.

(b) Effective with discharges on January 1, 1996, whether the patient's principal diagnosis, even if coded as a V code, was present at admission shall be reported as one of the following:

(1) Yes
(2) No
(3) Uncertain.

Authority: Section 443.45, Health and Safety Code.
Reference: Section 443.31, Health and Safety Code.

97226. Definition of Data Element - Other Diagnoses and Whether the Conditions were Present at Admission.

(a) 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

APPENDIX F

stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded. Diagnoses shall be coded according to the ICD-9-CM, except that psychiatric diagnoses may be coded according to the Diagnostic and Statistical

Manual of Mental Disorders, Fourth Edition, American Psychiatric Association, Washington, D.C. (DSM IV), Axes I, II, and III. ICD-9-CM codes from the supplementary classification of external causes of injury and poisoning (E800-E999) shall not be reported as other diagnoses.

(b) Effective with discharges on January 1, 1996, whether the patient's other diagnoses, including V codes, were present at admission shall be reported as one of the following:

(1) Yes
(2) No
(3) Uncertain.

Authority: Section 443.45, Health and Safety Code.
Reference: Section 443.31, Health and Safety Code.

97227. Definition of Data Element--External Cause of Injury.

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), which are codes used to describe the external cause of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external cause shall be reported for discharges 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, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported only for the first inpatient hospitalization during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause(s), the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If the first E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an additional E-code shall be reported to designate the place of occurrence, if available in the medical record. Up to three additional E-codes shall be reported, if necessary to completely describe the mechanism(s) that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect first diagnosed and/or treated during the current inpatient hospitalization.

Authority: Section 443.45, Health and Safety Code.
Reference: Section 443.31, Health and Safety Code.

97228. Definition of Data Element--Principal Procedure and Date.

APPENDIX F

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. Coding shall be 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 DRG assignment. The date the principal procedure was performed shall be reported in numeric form as follows: the 2-digit month, 2-digit day and 2-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 443.45, Health and Safety Code.
Reference: Section 443.31, Health and Safety Code.

97229. Definition of Data Element--Other Procedures and Dates.

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 DRG assignment. The dates shall be recorded with the corresponding other procedures and be reported in numeric form as follows: the 2-digit month, 2-digit day and 2-digit year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 443.45, Health and Safety Code.
Reference: Section 443.31, Health and Safety Code.

97230. Definition of Data Element--Total Charges.

The total charges are defined as all charges for services rendered during the length of stay for patient care at the facility, based on the hospital's full established rates. Charges shall include, but not be limited to, daily hospital services, ancillary services and any patient care services. Hospital-based physician fees shall be excluded. Prepayment (e.g. deposits and prepaid admissions) shall not be deducted from Total Charges. If a patient's length of stay is more than 1 year (365 days), record Total Charges for the last year (365 days) of stay only.

Authority: Section 443.45, Health and Safety Code.
Reference: Section 443.31, Health and Safety Code.

97231. Definition of Data Element--Disposition of Patient.

APPENDIX F

(a) Discharges occurring before January 1, 1995 shall have the patient's disposition, defined as the consequent arrangement or event ending a patient's stay in the facility, reported as one of the following:

APPENDIX F

(1) Routine Discharge. All patients discharged from the hospital to return home or to another private residence. Patients scheduled for follow-up care at a physician's office, or a clinic shall be included. Patients referred to a home health service shall not be included.

(2) Short-Term Acute Care Hospital. Transfer to a short-term acute care hospital or from another level of care within the hospital to short-term care within the hospital.

(3) Intermediate Care Facility. Transfer to an intermediate care facility (free-standing or hospital-based) or from another level of care within the hospital to intermediate care within the hospital.

(4) Skilled Nursing Facility. Transfer to a skilled nursing facility (free-standing or hospital-based) or from another level of care within the hospital to skilled nursing within the hospital.

(5) Other Facility. Transfer to a facility other than a short-term acute care hospital, intermediate care facility, or skilled nursing facility.

(6) Left Against Medical Advice. All patients who left the hospital without a physician's discharge order. Psychiatric patients discharged from AWOL status are included in this category.

(7) Home Health Service. Refer to a licensed home health service program.

(8) Died. All episodes of inpatient care which terminated in death.

(b) Effective with discharges occurring January 1, 1995 through December 31, 1996, the patient's disposition, defined as the consequent arrangement or event ending a patient's stay in the facility, shall be reported as one of the following:

(1) Routine Discharge. A patient discharged from the hospital to return home or to another private residence. Patients scheduled for follow-up care at a physician's office, or a clinic shall be included. Excludes patients referred to a home health service.

(2) Acute care within this hospital. A patient discharged to inpatient hospital care which is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, etc. unit within this reporting hospital.

(3) 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 the reporting hospital.

APPENDIX F

(4) Long Term Care within this hospital. A patient discharged to a Skilled Nursing/Intermediate Care Distinct Part within this reporting hospital.

(5) Acute care at another hospital. A patient discharged to another hospital to receive inpatient care which is of a medical/surgical nature, such as to a perinatal, pediatric, intensive, coronary, respiratory, newborn intensive care, or burn unit of another hospital.

(6) 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.

(7) Long Term Care, elsewhere. A patient discharged from this hospital to a Skilled Nursing/Intermediate Care level of care, either freestanding or a distinct part within some other hospital, or to a Congregate Living Health Facility as defined in Health and Safety Code Section 1250(i).

(8) Residential Care Facility. A patient discharged to a facility which provides special assistance to its residents in activities of daily living, but which provides no organized health care.

(9) Jail, Prison. A patient discharged to a correctional institution.

(10) Against Medical Advice. Patient left the hospital against medical advice, without a physician's discharge order. Psychiatric patients discharged from AWOL status are included in this category.

(11) Died. All episodes of inpatient care which terminated in death. Patient expired after admission and before leaving the hospital.

(12) Home Health Service. A patient referred to a licensed home health service program.

(13) Other. A patient discharged to some place other than mentioned above. Includes patients discharged to a VA facility or to an inpatient hospice facility that is not part of a hospital.

(c) Effective with discharges on January 1, 1997, the patient's disposition, defined as the consequent arrangement or event ending a patient's stay in the facility, shall be reported as one of the following:

(1) Routine Discharge. A patient discharged from the hospital to return home or to another private residence. Patients scheduled for follow-up care at a physician's office, or a clinic shall be included. Excludes patients referred to a home health service.

APPENDIX F

(2) Acute care within this hospital. A patient discharged to inpatient hospital care which is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, etc. unit within this reporting hospital.

(3) 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 the reporting hospital.

(4) Long Term Care within this hospital. A patient discharged to a Skilled Nursing/Intermediate Care Distinct Part within this reporting hospital.

(5) Acute care at another hospital. A patient discharged to another hospital to receive inpatient care which is of a medical/surgical nature, such as to a perinatal, pediatric, intensive, coronary, respiratory, newborn intensive care, or burn unit of another hospital.

(6) 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.

(7) Long Term Care, elsewhere. A patient discharged from this hospital to a Skilled Nursing/Intermediate Care type of care, either freestanding or a distinct part within some other hospital, or to a Congregate Living Health Facility as defined in Health and Safety Code Section 1250(i).

(8) Residential Care Facility. A patient discharged to a facility which provides special assistance to its residents in activities of daily living, but which provides no organized health care.

(9) Prison/Jail. A patient discharged to a correctional institution.

(10) Against Medical Advice. Patient left the hospital against medical advice, without a physician's discharge order. Psychiatric patients discharged from AWOL status are included in this category.

(11) Died. All episodes of inpatient care which terminated in death. Patient expired after admission and before leaving the hospital.

(12) Home Health Service. A patient referred to a licensed home health service program.

(13) Other. A patient discharged to some place other than mentioned above. Includes patients discharged to a VA facility or to an inpatient hospice facility that is not part of a hospital.

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

97232. Definition of Data Element--Expected Source of Payment.

(a) For each discharge occurring before January 1, 1995, report the patient's expected principal source of payment, defined as the source which is expected to pay the greatest share of the patient's bill, as one of the following:

(1) Medicare. Defined in Title XVIII of the Social Security Act (42 USC 1395 et seq.) and Title I of the Federal Medicare Act (PL 89-97). Includes crossovers to secondary payers.

(2) Medi-Cal. Defined in Title XIX of the Social Security Act and Title I of the Federal Medicare Act (PL 89-97).

(3) Workers' Compensation. Payment by Workers' Compensation Insurance.

(4) Title V. Maternal and Child Health. Defined in Title V of the Federal Medicare Act (PL 89-97). Applies only to females aged 60 or younger or males aged 21 or younger.

(5) Other Government. Any form of payment by government agencies, whether local, state, or federal, except Medicare, Medi-Cal, Title V (Maternal and Child Health), or MISP (Medically Indigent Services Program). Coded here are Short-Doyle and CHAMPUS.

(6) Blue Cross/Blue Shield. Payment covered by a Blue Cross/Blue Shield plan.

(7) Insurance Company. Payment covered by any private or commercial insurance carrier.

(8) HMO/PHP. Payment covered by a Health Maintenance Organization or Pre-paid Health Plan.

(9) Self Pay. Payment directly by the patient, guarantor, relatives or friends.

(10) No Charge. No payment expected by the facility. Coded here are free, charity, special research or Hill-Burton patients.

(11) Other Non-governmental. Any third party payment not included in the above options. Coded

APPENDIX F

here are payment by sources such as: self-insured or self-funded plans; by local or organized charities, such as the Cerebral Palsy Foundation.

APPENDIX F

(12) Medically Indigent Services Under Section 17000. Payment rendered to persons certified eligible for care under Section 17000, Welfare and Institutions Code. Includes payment for indigent care made directly by counties, and payment for services rendered to County Medical Services Program (CMSP) eligibles made by the State's fiscal intermediary.

(b) Effective with discharges on January 1, 1995, the patient's expected principal source of payment, defined as the source which is expected to pay the greatest share of the patient's bill, shall be reported using the following categories:

(1) Medicare. Defined in Title XVIII of the Social Security Act (42 USC 1395 et seq.) and Title I of the Federal Medicare Act (PL 89-97). Includes crossovers to secondary payers. Report Medicare patients covered under an HMO or PPO arrangement as Medicare.

(2) Medi-Cal. Defined in Title XIX of the Social Security Act and Title I of the Federal Medicare Act (PL 89-97). Report Medi-Cal patients covered under an HMO or PPO or other type of managed care arrangement as Medi-Cal.

(3) Workers' Compensation. Payment from Workers' Compensation insurance.

(4) County Indigent Programs. Any payment from county funds, whether from county general funds or from other funds used to support county health programs. Includes County Medical Services Program (CMSP), California Health Care for Indigent Program (CHIP), etc.

(5) CHAMPUS/CHAMPVA/VA. Any payment from the Civilian Health and Medical Program of the Uniformed Services or the Civilian Health and Medical Program of the Veterans Administration, or the Veterans Administration.

(6) Other Governmental. Any form of payment from American government agencies, whether local, state, or federal, except those listed above. Coded here are California Children Services (CCS), Title V, and Short-Doyle. Exclude payment by governments of other countries, such as Canada, Kuwait, etc.

(7) Health Maintenance Organization (HMO). Report Medicare patients covered under an HMO arrangement as Medicare. Report Medi-Cal patients covered under an HMO arrangement as Medi-Cal.

(8) Preferred Provider Organization (PPO). Report Medicare patients covered under a PPO arrangement as Medicare. Report Medi-Cal patients covered under a PPO arrangement as Medi-Cal.

APPENDIX F

(9) Private Insurance Company (non-HMO, non-PPO). Payment covered by any private or commercial insurance carrier, not under an HMO or PPO basis.
(10) Blue Cross/Blue Shield (non-HMO, non-PPO). Payment covered by a Blue Cross/Blue Shield plan, not under an HMO or PPO basis.

(11) Self Pay. Payment directly by the patient, guarantor, relatives or friends. The greatest share of the patient's bill is not expected to be paid by any form of insurance or other third party.

(12) Charity Care. A patient receiving care pursuant to Hill Burton obligations or who meets the standards for charity care pursuant to the hospital's established charity care policy.

(13) No Charge. No charge will be made by the facility. Coded here are free, special research, or courtesy patients.

(14) Other Non-governmental. Any third party payment not included in the above options. Coded here are payment by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, Shriners, etc., and payments by other countries.

Where payment is under a self-insured or self-funded plan, the category to be used is the one most descriptive of the third-party administrator. For example, if the self-insured or self-funded plan is administered by Blue Cross/Blue Shield, then Blue Cross/Blue Shield should be reported as the expected source of payment; if the third-party administrator is an HMO, then HMO should be reported as the source; similar choices should be made if the third-party administrator is a PPO or Private Insurance Company.

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

97239. Hospital Identification Number.

Effective with discharges through December 31, 1994, the unique nine-digit hospital identification number used by the Office's Discharge Data Program shall be reported for each patient record, either on the Individual Hospital Transmittal Form (OSHPD 1370.1) which must accompany data submitted on the discharge data abstract form (OSHPD 1370), or in positions 1 through 9 of computer media format. Effective with discharges on January 1, 1995, the last six digits of the existing nine-digit identification number shall be reported as part of each patient record, either in the specified section of the discharge data abstract form (OSHPD 1370), or in positions 2 through 7 on computer media format.

APPENDIX F

Authority: Section 128765, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

APPENDIX F

97240. Request for Modifications to the California Hospital Discharge Data Set.

(a) Hospitals may file a request with the Office for modifications to the California Hospital Discharge Data Set. The modification request must be supported by a detailed justification of the hardship that full reporting of discharge data would have on the hospital; an explanation of attempts to meet reporting requirements; and, a description of any other factors that might justify a modification. Modifications may be approved for only one year. Each hospital with an approved modification must request a renewal of that approval 60 days prior to termination of the approval period in order to have the modification continue in force.

(b) The criteria to be considered and weighed by the Office in determining whether a modification to discharge data reporting requirements may be granted are as follows:

(1) The modification would not impair the ability of either providers or consumers to make informed health care decisions.

(2) The modification would not deprive the public of data needed to make comparative choices with respect to scope or type of services or to how services are provided, and with respect to the manner of payment.

(3) The modification would not impair any of the goals of the Act.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128735 and 128760, Health and Safety Code.

97241. Requests for Extension of Time to File Discharge Data.

Extensions are available to hospitals that are unable to complete their submission of patient discharge data by the due date prescribed in Section 97211. A maximum of 60 days is allowed for all extensions, corrections and resubmittals. Hospitals are encouraged to file extension requests as soon as it is apparent that the required data will not be completed for submission on or before their due date. The request for extension shall be postmarked on or before the required due date of the data and supported by a letter of justification which may provide good and sufficient cause for the approval of the extension request. To provide the Office a basis to determine good and sufficient cause, the letter of justification shall include a factual statement indicating:

(1) the actions taken by the hospital to produce the discharge data reports by the required deadline;

(2) those factors which prevent completion of the reports by the deadline; and

(3) those actions and the time (days) needed to accommodate those factors.

The Office shall respond within 10 days of receipt of the request by either granting what is determined to be a reasonable extension or disapproving the request. If disapproved, the Office shall set forth the basis for a denial in a notice to the hospital sent by certified mail. The Office may seek additional information from the requesting hospital. The Office shall not grant extensions which exceed an accumulated total of 60 days for all extensions and corrections of discharge data. If a hospital 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 hospital which wishes to contest any decision of the Office shall have the right of appeal, as provided by Section 97052.

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

97242. Error Tolerance Levels.

(a) The error tolerance levels for discharge data items reported to the Office shall be as shown in Table 1. An error percentage that exceeds a specified error tolerance level shall be corrected by the hospital to the specified tolerance level.

(b) For error tolerance levels for "admission date" and "discharge date" that do not exceed the error tolerance levels specified in Table 1, the Office shall delete the hospital's entire record if the hospital fails to correct the data after a 30 calendar day notification by the Office of the error(s).

(c) Effective with discharges occurring July 1, 1990 and thereafter, for error tolerance levels for data elements other than "admission date" and "discharge date" that do not exceed the error tolerance levels specified in Table 1, the Office shall assign default values as shown in Table 2 if the hospital fails to correct the data after a 30 calendar day notification by the Office of the error(s).

APPENDIX F

Table 1. Discharge Data Error Tolerance Levels

Data Element	Error Tolerance Level
Date of Birth	.1%
Sex	.1%
Race	5%
Zip Code	5%
Social Security Number	.1%
Admission Date	.1%
Source of Admission	5%
Type of Admission	5%
Discharge Date	.1%
Principal Diagnosis	.1%
Principal Diagnosis - Present at Admission	.1%
Other Diagnoses	.1%
Other Diagnoses - Present at Admission	.1%
External Cause of Injury	.1%
Principal Procedure	.1%
Principal Procedure Date	1%
Other Procedures	.1%
Other Procedures Dates	1%
Total Charges	.1%
Disposition of Patient	1%
Expected Principal Source of Payment	.1%

APPENDIX F

Table 2. Discharge Data Error Tolerance Level Default Values

Data Element	Default Value
Date of Birth	0
Sex	[unknown]
Race	[unknown]
Zip Code	XXXXX
Social Security Number	000000001
Source of Admission	0
Type of Admission	[unknown]
Principal Diagnosis	799.9
Principal Diagnosis - Present at Admission	Yes
Other Diagnoses	[blank]
Other Diagnoses - Present at Admission	Uncertain
External Cause of Injury	[blank]
Principal Procedure	[blank]
Principal Procedure Date	0
Other Procedures	[blank]
Other Procedures Dates	0
Total Charges	0
Disposition of Patient	0
Expected Principal Source of Payment	0

(d)(1) The error tolerance level of "sex" shall include "unknown".

(2) The error tolerance level for "race" shall include "unknown".

(3) The error tolerance level for "ZIP code" shall include "partial and unknown".

(4) The error tolerance level for "type of admission" shall include "unknown".

(5)(a) The error tolerance level for both "principal diagnosis" and "other diagnoses" shall, for any one

record, count all errors made in coding diagnoses as one error.

APPENDIX F

(b) The error tolerance level for "principal diagnosis - present at admission" and "other diagnoses - present at admission" shall, for any one record, count all errors made as one error.

(6) The error tolerance level for both "principal procedure" and "other procedures" shall, for any one record, count all errors made in coding procedures as one error.

(7) The error tolerance level for both "principal procedure date" and "other procedure dates" shall, for any one record, count all errors made in coding date as one error.

(8) The error tolerance level for "social security number" shall include "blank" and "invalid."

(9) The error tolerance level for "external cause of injury" shall include "invalid."

Authority: Section 443.45, Health and Safety Code.
Reference: Section 443.31, Health and Safety Code.

97243. Acceptance Criteria.

(a) The report shall not be accepted but shall be rejected and returned to the hospital by the Office if the following requirements are not met:

(1) A completed and appropriate transmittal form must be submitted with the report, pursuant to Section 97214.

(2) If the data are submitted on computer media, the hospital or its agent, if the hospital has designated one, shall have demonstrated compliance with the Office's standard format and specifications by having previously submitted a set of data which the Office approved as being in conformance to the applicable standard format and specifications, pursuant to Section 97215.

(3) The appropriate version of the discharge data reporting form (OSHPD 1370), as specified in Section 97215, must be used when reporting other than on magnetic tape or diskette.

(4) The hospital, abstractor, data processing firm, or other third party submitting the data must be in accordance with the most recent designation furnished by the hospital to the Office, pursuant to Section 97210.

(b) After a report submitted on computer media is accepted, the hospital may be required to replace the data, after having corrected data and other problem(s), if any of the following circumstances pertain:

APPENDIX F

(1) The Office was unable to read the computer media submitted.

(2) When the computer file was read, it contained no data, contained data not covering the full report period, or contained fewer records than stated on the transmittal form.

(3) The data were not reported in compliance with Section 97215 (standard format and specifications).

(4) The hospital identification number on each of the records being reported for the hospital does not agree with that hospital's identification number specified on the transmittal form, pursuant to Section 97214.

(5) Over 600 corrections are required as a result of not meeting the Office's data element definitions specified in Sections 97216 through 97232, and editing criteria as set forth in the Office's "Discharge Data Program Editing Criteria Handbook," as revised. Any hospital or other interested party may obtain a free copy of the current version of the "Discharge Data Program Editing Criteria Handbook," from the Office's Discharge Data Program. The Office shall send a copy of the current version of the "Discharge Data Program Editing Criteria Handbook," along with the request for replacement, if the contents are relevant to the reasons the replacement is requested.

(c) After a report is accepted, the hospital may be required to supply corrections if any of the following circumstances pertain:

(1) All inpatient discharges, as defined in Office regulation 97212 (c), were not reported.

(2) Between 75 and 600 records require correction as a result of not meeting the Office's data element definitions specified in Sections 97216 through 97232, and editing criteria as set forth in the Office's "Discharge Data Program Editing Criteria Handbook," as revised. Any hospital or other interested party may obtain a free copy of the current version of the "Discharge Data Program Editing Criteria Handbook," from the Office's Discharge Data Program. The Office shall send a copy of the current version of the "Discharge Data Program Editing Criteria Handbook," along with the request for corrections, if the contents are relevant to the reasons the corrections are requested.

(d) If a hospital is required to replace or correct their discharge data, the Office shall allow a specified number of days for correction or replacement and shall establish a due date for resubmittal of the corrections or replacement. In determining the number of days to be allowed, the Office shall take account of the number and degree of errors and the number of extension days already granted, but in no case shall an aggregate total of more than 60 days for all extensions, corrections, replacements, and resubmittals be allowed.

APPENDIX F

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