MIRCal – Data Specific FAQs

Frequently asked questions pertinent to specific data types are listed below. Many of these questions are answered in greater detail in our data reporting manuals.

Inpatient (IP) Specific FAQs:

1. What are the file specifications (format) for inpatient data submissions?

   The information for inpatient data submissions is available in the Format and File Specifications document found on the Inpatient resources page.

2. What are the inpatient report periods and due dates?

   As per Title 22 Regulations, there are two Inpatient data report periods each year.

   Report Period: January 1 through June 30
   Due Date: September 30 of the same year

   Report Period: July 1 through December 31
   Due Date: March 31 of the following year

3. What codes are used for inpatient care?

   For current data reporting of discharges occurring October 1, 2015 and afterward, ICD-10-CM and ICD-10-PCS codes are to be used for inpatient diagnoses, procedures, and external causes of morbidity.

4. Will IP data elements be changed to National Standards in the future?

   The current IP data elements are defined in law. These were developed from Uniform Hospital Discharge Data Set (UHDDS) standards. Our statutory authority mandates that data reporting requirements be consistent with national standards, as applicable. OSHPD is gradually updating inpatient data elements to be in closer alignment and consistent with national standards based on the federal ANSI X12N 837 Health Care Service Data Reporting Guide and the OMB race and ethnicity standard.

5. What admission date do we report if an ED or AS patient came in on August 1st and was admitted to the same hospital on August 2nd?

   The admit date is August 2nd. This is clarified in the California Inpatient Data Reporting Manual under "Admission Date". It states: *patients are often seen in the emergency room on one day and remain until the next day and are then admitted to inpatient care. The admission date reported is the date the patient is actually admitted to inpatient care.* This is consistent with CMS requirements on admission date. This scenario may also apply to an AS patient. Do not confuse admission date with service date.

6. What do we report if an ED or AS patient is admitted to our hospital as an inpatient?

   MIRCal Regulation Section 97213 states that a hospital shall not report an ED or AS record if the encounter resulted in a same-hospital admission. The ED or AS data record would be combined with the inpatient record. Keep in mind that the inpatient record has different coding structures for many data elements. You would follow the requirements for reporting the inpatient record. The procedure dates showing three days (or 72 hours) prior to admission will be accepted. This has been in practice since 1993 when hospitals were concerned with CMS requirements requiring them to bundle related records together.

Emergency Department (ED) and Ambulatory Surgery (AS) Specific FAQs:

7. Do we report services provided in observation to OSHPD?

   An ED or AS record must be reported to OSHPD if an encounter took place as defined in Section 97212 (i), regardless of whether a patient was placed in observation status. Your facility can make the determination to include the observation stay on the ED, AS, or IP record, and this combined record must include all diagnoses, procedures, and external cause codes as required. Reporting observation status is not currently required. Since the patient is expected to go home after observation, discharge status would be “home”.

8. What are the ED and AS report periods and due dates?

   As per Title 22 Regulations, there are four ED and AS data report periods each year. The report due date is 45 calendar days after the end of each quarterly report period.

   Report Period: January 1 through March 31
   Due Date: May 15 of the same year

   Report Period: April 1 through June 30
   Due Date: August 14 of the same year

   Report Period: July 1 through September 30
   Due Date: November 14 of the same year

   Report Period: October 1 through December 31
   Due Date: February 14 of the following year

9. Why are providers required to report their data to OSHPD?

   Inpatient discharge data have been collected and used since 1980. Today, data users want more timely information on the healthcare Californians are receiving. To meet the healthcare industry and public's demand, legislation was passed in 1998 to collect Emergency Department and Ambulatory Surgery data. Sections 128736 and 128737 of the California Health and Safety Code dictate that Emergency Department data and Ambulatory Surgery data shall be reported to OSHPD.

10. What range of CPT codes should be reported to OSHPD?

    The CPT code range accepted by OSHPD includes any of the 00001-99999 (Category I codes) and the "T" codes (Category III codes) that qualify as surgical risk, procedural risk and/or anesthetic risk. Modifiers or the optional "F" codes (Category II codes) or any of the HCPCS Level II or III codes will not be accepted as valid CPT codes. For further information on required reporting, reference the Principal Procedure and Other Procedures chapters of our ED & AS Data Reporting Manual.

11. Do we have to report modifiers? Do we report F codes and T codes?

    Modifiers are not accepted when reporting to OSHPD. The full range of CPT codes, except those in Category II, should be used to report ambulatory surgery procedures performed.

    Category I CPT codes, established by the CPT Editorial Panel, are required for reporting services and procedures performed to OSHPD.

    Category II CPT codes (F codes), as a set of supplemental tracking codes for performance measurements, are not accepted when reporting to OSHPD.

    Category III CPT codes (T codes), as a set of temporary codes for emerging technology, services, and procedures, are required to be used instead of Category I's unlisted codes when reporting to OSHPD.

12. What will the data be used for?

    Data users request patient data for a variety of purposes. Some current uses of inpatient data include injury surveillance and child injury prevention. Facilities also request data for internal quality assurance measuring, product development, and market-share analysis. Future uses of ED data may be emergency medical service planning and identifying trends in the utilization of Emergency Department settings. Future uses of AS data may be planning ambulatory surgery services and identifying trends in the utilization of AS settings. Patient data provide vital information for improving healthcare for Californians.

Emergency Department (ED) Specific FAQs:

13. What service date do we report if an ED patient came in on June 30th, stayed overnight, and was dismissed on July 1st?

    The service date is the start of care. Care began on June 30th and ended on July 1st. In billing, there are terms like "From Date" and "To Date". The start of care would be considered the beginning of the encounter. The definition of an encounter is a face-to-face contact between an outpatient and a provider. This record would be reported in the April through June report period.

Ambulatory Surgery (AS) Specific FAQs:

14. What is an Ambulatory Surgery Clinic (ASC)?

    Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization. A surgical clinic may be hospital-operated or "freestanding" and provides ambulatory surgical care for patients who remain less than 24 hours. A "freestanding" ambulatory surgery clinic is licensed by the state (Section 1204, paragraph 1 of subdivision B) and is not a part of a hospital.

15. Which hospitals must report outpatient surgery procedures?

    Senate Bill (SB) 1973 states that hospitals and freestanding licensed ambulatory surgery clinics are required to report to OSHPD if they perform procedures on an outpatient basis in:

    - General Operating Rooms
    - Ambulatory Surgery Rooms
    - Endoscopy Units
    - Cardiac Catheterization Laboratories

16. What service date do we report if an AS patient came in on June 30th, stayed overnight, and was dismissed on July 1st?

    The service date is the start of care. Care began on June 30th and ended on July 1st. In billing, there are terms like "From Date" and "To Date". The start of care would be considered the beginning of the encounter. The definition of an encounter is a face-to-face contact between an outpatient and a provider. This record would be reported in the April through June report period.

17. What admit date do we report if an AS patient came in on August 1st and was admitted to the same hospital on August 2nd?

    The admit date is August 2nd. This is clarified in the California Inpatient Data Reporting Manual under "Admission Date". It states, "Patients are often seen in the emergency room on one day and remain until the next day and are then admitted to inpatient care." The admission date reported is the date the patient is actually admitted to inpatient care. This is consistent with CMS requirements on admission date. Do not confuse admission date with service date.

18. What do we report if an AS patient was sent to observation and then was admitted to our hospital?

    MIRCal Regulation Section 97213 for Required Reporting states that a hospital shall **not** report an Ambulatory Surgery Data Record if the encounter resulted in a **same-hospital admission**. The AS data record would be combined with the inpatient record. Keep in mind that the inpatient record has different coding structures for many data elements. Follow the requirements for inpatient reporting. Procedure dates showing three days (or 72 hours) prior to admission will be accepted on the IP record. This has been in practice since 1993 when hospitals were concerned with CMS requirements requiring them to bundle related records together.

19. Do we need to submit procedure data for every patient that comes to our facility?

    Encounter data must be reported if these **two criteria are fulfilled:**

    - Procedure is performed on an outpatient basis, and
    - Procedure is performed in one of these specified areas: general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding AS clinic.

    When both of the above criteria are met, then your facility must report the data record following all of the data reporting requirements. Also reference the Principal Procedure and Other Procedures chapters of our ED & AS Data Reporting Manual to ensure accurate reporting meeting the regulatory definition of required procedures.