REPORTING REQUIREMENTS

NOTE: **The regulations are identified by bold and italics.**

The section number located at the top right corner of the first page of each regulation refers to the California Code of Regulations, Title 22, Division 7, Chapter 10, Article 8.

CONTACT PERSON, USER ACCOUNT ADMINISTRATOR, AND FACILITY IDENTIFICATION NUMBER — Section 97210

(a) Each reporting facility shall designate a primary contact person and shall notify the Department's Patient Data Program in writing, by electronic mail, or through the Department's online submission system of the designated person's name, title, telephone number(s), mailing address, and electronic mail address. The designated person will be sent time-sensitive electronic mail regarding the facility's data submission, including reminder notices, acceptance and rejection notifications, and extension information.

DISCUSSION

Some responsibilities of the primary contact designated by the facility are to:

- respond appropriately to law, regulations, and notices from HCAI. The facility must meet each deadline or incur a civil penalty of $100 for every day the data are late. The facility may request an extension for the deadline.
- respond appropriately to HCAI's questions about errors in the data, by coordinating a new submission or correction of the data.
- assist the facility in meeting its reporting obligations by directing HCAI's requests for corrections to the appropriate personnel within the facility and coordinating the facility's response to HCAI.

(b) Each reporting facility shall notify the Department's Patient Data Program in writing, by electronic mail, or through the Department's online submission system within 15 days after any change in the person designated as the primary contact person, or in the designated primary person's name, title, telephone number(s), mailing address, or electronic mail address.

DISCUSSION

A change in the designated primary contact refers to a person who handles all correspondence with HCAI on behalf of the facility.

(c) Each reporting facility beginning or resuming operations, whether in a newly constructed facility or in an existing facility, shall notify the Department's Patient Data Program in writing, by electronic mail or through the Department's online submission system within 30 days after its first day of operation of the designated primary contact person and the facility administrator.

DISCUSSION

See Subsection (a) of Section 97210 for discussion of the primary contact person.

After HCAI receives notification, the facility will be notified of its unique Facility Identification Number, as assigned by HCAI, to be used on each data record.

(d) Each reporting facility shall designate User Account Administrators pursuant to Subsection (c) of Section 97246. Each reporting facility shall notify the Department's Patient Data Program in writing, by electronic mail or through the Department's online submission system within 15 days after any change in a designated user account administrator's name, title, telephone number(s), mailing address, or electronic mail address.

DISCUSSION

It is the reporting facility's responsibility to update and maintain each User Account Administrator (UAA) profile within 15 days of any changes.

User Account Administrators who are no longer with the facility or no longer responsible for HCAI data should be inactivated and the UAA role deselected immediately.

The Facility User Account Administrator Agreement form (UAA form) can be found on the HCAI website. The administrator name on the submitted form must match the current Administrator name HCAI has on file.

(e) Each reporting facility may submit its own data report to the Department's Patient Data Program, or it may use an agent for this purpose. The reporting facility shall be responsible for ensuring compliance with regulations and reporting requirements when an agent is used.

DISCUSSION

It is the reporting facility that is ultimately responsible for ensuring that its data is submitted and corrected by the designated due date.

(f) Each reporting facility shall be provided a facility identification number that shall be used to submit data to the Department.

DISCUSSION

Each reporting facility will be notified by HCAI of its unique facility identification number to be used on each data record.

REPORTING PERIODS AND DUE DATES — Section 97211

(a) The prescribed reporting periods are:

(1) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(2) Calendar quarterly for Emergency Care Data reports, which means there are four reporting periods each year, consisting of encounters occurring January 1 through March 31, encounters occurring April 1 though June 30, encounters occurring July 1 through September 30, and encounters occurring October 1 through December 31.

(3) Calendar quarterly for Ambulatory Surgery Data reports, from a hospital or from a freestanding ambulatory surgery clinic, which means there are four reporting periods each year, consisting of encounters occurring January 1 through March 31, encounters occurring April 1 though June 30, encounters occurring July 1 through September 30, and encounters occurring October 1 through December 31.

DISCUSSION

REPORTING PERIODS
January 1 through March 31
April 1 through June 30
July 1 through September 30
October 1 through December 31

(b) Where there has been a change in the licensee, the effective date of the change shall constitute the start of the reporting period for the new licensee. The end of the first reporting period for the new licensee shall be the end of the prescribed reporting period. The final day of the reporting period for the previous licensee shall be the last day their licensure was effective.

DISCUSSION

Example: If a facility's licensee changes effective May 1, the first report for the new licensee will cover the period from May 1 through June 30 and will be due

on August 14. The final report for the previous licensee will cover the period April 1 through April 30, and will be due August 14.

PREVIOUS LICENSEE		**NEW LICENSEE**	
REPORTING PERIOD	**DUE DATE**	**REPORTING PERIOD**	**DUE DATE**
April 1 through April 30	August 14	May 1 through June 30	August 14

(c) Report due dates:

(1) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(2) For Emergency Care Data reports, for encounters occurring on or after October 1, 2004, and all subsequent report periods, the report due date shall be 45 days after the end of each reporting period; thus the due date for the January 1 through March 31 reports is May 15 of the same year, the due date for the April 1 though June 30 reports is August 14 of the same year, the due date for the July 1 through September 30 reports is November 14 of the same year, and the due date for the October 1 through December 31 reports is February 14 of the following year.

(3) For Ambulatory Surgery Data reports, for encounters occurring on or after October 1, 2004, and all subsequent report periods, the report due date shall be 45 days after the end of each reporting period; thus the due date for the January 1 through March 31 reports is May 15 of the same year, the due date for the April 1 though June 30 reports is August 14 of the same year, the due date for the July 1 through September 30 reports is November 14 of the same year, and the due date for the October 1 through December 31 reports is February 14 of the following year.

DISCUSSION

REPORTING PERIOD	**DUE DATE**
January 1 through March 31	May 15 of the same year
April 1 through June 30	August 14 of the same year
July 1 through September 30	November 14 of the same year
October 1 through December 31	February 14 of the following year

If the due date falls on a Saturday, Sunday, or State of California holiday, facilities may submit data the next State of California business day without penalty. If not submitted by this time, penalty will accrue from the due date to the date submitted.

Example: If data are due on Saturday and your facility submits your data or an extension request on Monday, no penalties will apply. If you submit on Tuesday, penalties will be assessed based upon the due date. A penalty would be assessed for Sunday, Monday, and Tuesday.

(d) Data reports shall be filed, as defined by Subsection j of Section 97005, by the date the data report is due. Where a reporting facility has been granted an extension, pursuant to Section 97241, the ending date of the extension shall constitute the new due date for that data report.

DISCUSSION

Subsection (j) of Section 97005 reads:

(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.

DEFINITIONS, AS USED IN THIS ARTICLE — Section 97212

(a) Ambulatory Surgery (AS) Data Record. The Ambulatory Surgery Data Record consists of the set of data elements related to an encounter, as specified in Subsection (a) of Section 128737 of the Health and Safety Code and as defined in Sections 97251-97265 and 97267-97268 of the California Code of Regulations.

DISCUSSION

Each AS encounter should have at least one ambulatory surgery procedure as specified in Subsection (a)(3) of Section 97213.

Ambulatory surgery procedures as defined in Subsection (a) of Section 128700 of the Health and Safety Code are those procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units or cardiac catheterization laboratories of a hospital or freestanding ambulatory surgery clinic.

An Ambulatory Surgery Room is a designated outpatient surgery service space within an outpatient setting. It also may be referred to as a Treatment Room, Procedure Room, Small Ambulatory Room, or Outpatient Surgery Suite. Regardless of terminology, an ambulatory surgery room must meet specific requirements as specified in Title 22 of the California Code of Regulations, Division 5, Chapter 1, Article 6, Section 70533.

(b) CPT-4. The Current Procedural Terminology, 4th Edition, is published and maintained by the American Medical Association. It is a standard medical code set for healthcare services or procedures in non-inpatient settings.

(c) Days. Days, as used in this article, are defined as calendar days unless otherwise specified.

(d) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(e) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(f) Emergency Care Data Record. The Emergency Care Data Record consists of the set of data elements related to an encounter, as specified in Subsection (a) of Section 128736 of the Health and Safety Code and as defined in Sections 97251-97265 and 97267-97268.

DISCUSSION

All significant procedures (per Section 97263) that are related to and performed as the result of the encounter must be reported on the ED record, regardless of whether the procedures were performed in the ED room.

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

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

DISCUSSION

See discussion in Subsection (r) of this Section for the definition of a provider.
Patients who are Dead on Arrival (DOA) should not be considered an encounter.
A separate ED or AS record should not be created and reported to HCAI for the purpose of organ harvesting.

Telemedicine is not considered to be a face-to-face encounter.

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

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

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

DISCUSSION

A freestanding licensed surgery clinic is not part of a hospital and it provides ambulatory surgical care for patients who remain less than twenty-four hours.

(l) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(m)

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

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

(n) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(o) Licensee. Licensee means an entity that has been issued a license to operate a facility, as defined by Subsection (d) or (f) of Section 128700 of the Health and Safety Code.

(p) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(q) Outpatient. An Outpatient means:

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

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

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

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

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

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

(v) SIERA. SIERA means the Department's System for Integrated Electronic Reporting and Auditing that is a secure online transmission system through which reports are submitted and corrected, and report extension requests are submitted using an internet web browser. SIERA is available on the Department's internet web site at: https://siera.hcai.ca.gov.

(w) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(x) User Account Administrator. A healthcare facility representative responsible for designating users, which may include agents, and maintaining the facility's online submission system user accounts and user account contact information.

REQUIRED REPORTING **Section 97213**

(a) (1) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(2) Emergency Care Data: Each hospital shall submit an emergency care data record, as specified in Subsection (a) of Section 128736 of the Health and Safety Code, for each encounter during the quarterly reporting period, according to the format specified in Subsection (b) of Section 97215 and by the dates specified in Subsection(c)(2) of Section 97211. A hospital shall not report an Emergency Care Data Record if the encounter resulted in a same-hospital admission.

DISCUSSION

Scenario 1 - A patient is admitted to your facility as an inpatient from your Emergency Care. The Emergency Care record would be combined with the inpatient record. A separate ED record would not be reported to HCAI.

Scenario 2 - An Emergency Care patient is seen by a provider and sent home. Later on the same day the patient returns to the ED and is admitted as an inpatient for a related condition. The hospital would report an Emergency Care record for the first encounter and the second ED encounter would be reported as part of the inpatient record.

Scenario 3 - An Emergency Care patient is sent to the same facility's ambulatory surgery for a procedure. The Emergency Care encounter <u>may</u> be combined with the ambulatory surgery stay into one ED or AS encounter reported to HCAI.

(3) Ambulatory Surgery Data: Each hospital and freestanding ambulatory surgery clinic shall submit an ambulatory surgery data record, as specified in Subsection (a) of Section 128737 of the Health and Safety Code, for each encounter during which at least one ambulatory surgery procedure is performed, during the quarterly reporting period, according to the format specified in Subsection (c) of Section 97215 and by the dates specified in Subsection(c)(3) of Section 97211. An ambulatory surgery procedure is defined by Subsection (a) of Section 128700 of the Health and Safety Code as those procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic. A hospital shall not report an Ambulatory Surgery Data Record if the encounter resulted in a same-hospital admission.

DISCUSSION

For purposes of reporting to HCAI, a procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk. See sections 97262 and 97263 of the California Code of Regulations and the sections for Principal Procedure and Other Procedure in this manual.

Scenario 1 - A patient is admitted to your facility as an inpatient from your Ambulatory Surgery. The Ambulatory Surgery record would be combined with the inpatient record. A separate AS record would not be reported to HCAI.

Scenario 2 - An Ambulatory Surgery patient is sent home but returns to the hospital the next day and is admitted as an inpatient for a related condition. The hospital would report both an Ambulatory Surgery record and an inpatient record. The Ambulatory Surgery encounter would not be combined with the inpatient record.

Scenario 3 - An Ambulatory Surgery (hospital based) patient is sent to the same facility's emergency room. The Ambulatory Surgery encounter may be combined with the emergency room visit into one ED or AS encounter reported to HCAI.

(b) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(c) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(d) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(e) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(f) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(g) Licensees operating and maintaining more than one physical plant on separate premises under a single consolidated license who choose to file separate data reports for each location must request, in writing, a modification to file separate data reports for each location. A licensee granted a modification under this paragraph shall be responsible for all regulatory requirements for each separate report. Separate extension requests, filed under the provisions of Section 97241, shall be required for each report, and penalties, assessed pursuant to Section 97250, shall be assessed on each delinquent report.

DISCUSSION

Separate Reporting
A consolidated facility may elect to submit separate data reports for multiple sites using the existing separate Facility Identification Numbers. Prior to submitting separate data reports, a consolidated facility must request a modification.

Combined Reporting
If consolidated facilities are submitting together on one report, all data records must have the same Facility Identification Number.

Please see the Requests Section of this manual for information on modifications and extension requests.

FORMAT **Section 97215**

(a) This subsection applies to hospital inpatient data only and is not applicable to ED or AS.

(b) Emergency Care Data reports for encounters occurring on or after January 1, 2023, shall comply with the Department's Format and File Specifications for Online Transmission: Emergency Care and Ambulatory Surgery Data Version 3.1 as revised October 2022 and hereby incorporated by reference.

(c) Ambulatory Surgery Data reports for encounters occurring on or after January 1, 2023, shall comply with the Department's Format and File Specifications for Online Transmission: Emergency Care and Ambulatory Surgery Data Version 3.1 as revised October 2022 and hereby incorporated by reference.

(d) The Department's Format and File Specifications for Online Transmission as named in (a), (b), and (c) are available for download from the HCAI website. The Department will make a hardcopy of either set of Format and File Specifications for Online Transmission available upon request.

DISCUSSION

Format and File Specifications for Online Transmission are available for download from HCAI's website.

For online web entry see the Emergency Care Data Record Manual Abstract Reporting Tool (HCAI 1370.ED) and the Ambulatory Surgery Data Record Manual Abstract Reporting Tool (HCAI 1370.AS). These are available for download from HCAI's website.

METHOD OF SUBMISSION **Section 97244**

(a) For discharges or encounters occurring on or after January 1, 2021, reporting facilities shall use the Department's online submission system known as SIERA for submitting reports through either:

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

DISCUSSION

There are two options to submit data:

> Option ***(1)*** allows facilities to submit data reports as electronic data files by attaching a text (.txt) file. Other file formats, such as .xls, are not accepted.
>
> Option ***(2)*** allows facilities to enter individual records directly into the online submission system by using the online Record Entry Form. The option is not recommended for facilities with a large number of records, as it may be time-consuming.
>
> As a tool for online record entry, see the Manual Abstract Reporting Tool (HCAI 1370.ED and HCAI 1370.AS) available for download from HCAI's website.

There is no limit to the number of test submissions by a facility. Facilities have two options to make corrections to their data records:

1) Correcting the data in-house. Facilities may choose to make corrections to the data that resides within their own system and submit a new file. The new file with the corrections will override the previously submitted data in the online submission system.

2) Online corrections. You may go directly to any edit program's "Listing of Records for Correction" from the "Make Corrections" option in the online submission system. From there, you have the option to make the necessary changes to individual records.

Important: If you choose to make changes online, do not submit a new file. A new submitted file will overwrite the previously submitted data and any corrections made online. In order to save any online changes, be sure to choose "Submit Corrections."

ONLINE TEST OPTION — Section 97245

Reports may be tested before formal submission to the Department using the online test option. Online testing of the format and reports through the online test option, before formal transmission, is the recommended means of ensuring compliant data that meets the standards established by the Department before the due date. Reports tested through the online test option will be subject to the same processing and will generate the same reports as data that is formally submitted. The format and reports may be tested through the test option as many times as needed to assure that the reports meet the standards established by the Department in Section 97247.

DISCUSSION

A facility can test its data for errors through the online submission system's test feature. Once a report period has opened, data can be submitted using the test submission process. This test function processes data through the edit programs and generates summary and detail reports. Corrections and resubmissions through the test function may be made without the use of extension days until the established due date. If your data has not been formally approved by the due date, an extension request must be submitted to avoid penalties.

The test submission function is only a tool for correcting data and will not be considered as an official (formal) receipt of data by HCAI. A test submission does not prevent penalty accrual.

When the data is below the established Error Tolerance Level, as described in Section 97248, the submission status screen will inform you that the data is "Pending - Validation Passed." You may choose to submit as formal or correct any remaining edit flags.

Important: If you choose to make changes online, do not submit a new file. The new file will overwrite the previously submitted data and any corrections made online. In order to save any changes made in the online submission system, be sure to choose "Validate Report."

DATA TRANSMITTAL REQUIREMENTS **Section 97246**

(a) Data shall be submitted using the Department's online submission system to file or submit each report. The following information must be included: the facility name, the unique identification number specified in Section 97210, the beginning and ending dates of the report period, the number of records in the report and the following statement of certification:

I certify under penalty of perjury that I am an official of this facility and am duly authorized to submit these data; and that, to the extent of my knowledge and information, the accompanying records are true and correct, and that the applicable definitions of the data elements as set forth in Article 8 (Patient Data Reporting Requirements) of Chapter 10 (Health Facility Data) of Division 7 of Title 22 of the California Code of Regulations, have been followed by this facility.

(b) Reporting facilities with an approved exemption to submit records using a method other than The Department's online submission system must submit the following information: facility name, the unique identification number specified in Section 97210, the data type of the report, the report period of the records submitted, the number of records in the report, the medium of accompanying records, the certification language as provided in (a) above, with a signature of the authorized representative of the facility and contact information. The information shall accompany the report.

(c) A facility's administrator may designate User Account Administrators. For each User Account Administrator, there must be a signed facility User Account Administrator Agreement form (HCAI-OIS-773 Rev. August 2023), hereby incorporated by reference, submitted to the Department.

DISCUSSION

User Account Administrators (UAAs) are the facility staff responsible for maintaining their facility's user accounts and contact information. UAAs have access to add users, inactivate users and update contact information.

HCAI strongly recommends the assignment of more than one UAA in order to provide adequate coverage when one of the UAAs is not available or leaves the facility.

(d) ***Forms may be obtained from the Department of Health Care Access and Information web site at www.hcai.ca.gov or by contacting the Department's Patient Data Program at (916) 326-3935.***

FAILURE TO FILE A DATA REPORT **Section 97250**

Any health facility which does not file any report completed as required by this article 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 Department for each day that the filing of the report is delayed, considering all approved extensions of the due date as provided in Section 97241. Assessed penalties may be appealed pursuant to Section 97052. Within fifteen days after the date the reports are due, the Department shall notify the health facility of reports not yet received, the amount of the liability, and potential future liability for failure to file reports when due. Sixty days after an original report period due date as specified in Section 97211 (c), the Department's online submission system will close for that report period. No report for the period will be accepted after the system closure. No additional penalties will accrue for outstanding reports after the system closure for a report period.