Reporting Patient Level Data – FAQs

Patient Level Data (PLD) is submitted in the *System for Integrated Electronic Reporting and Auditing (*SIERA). Many of these questions are answered in greater detail in the resources found on the PLD Home Page.

General FAQs

System Requirements and File Format

1. What type of file will be used to submit data?

   The data must be text (.txt) files. Excel files are not accepted. Please view the appropriate data type File and Format Specifications for complete information.

2. When data is submitted to SIERA, is it secure?

   When facility users log in to the system and submit their file, it is encrypted and downloaded to HCAI over a secure internet connection.

3. Is the file format for Inpatient data different than the Emergency Department and Ambulatory Surgery data format?

   Facilities are required to report in two separate formats:
   - ED and AS format
   - Inpatient format

   You may review the format and file specifications for each data type on their perspective web page. Data files must be separate for each data type.

Data Submission

4. Is there any way to check my file format?

   Yes. You may submit a file at any point in the report period to check the format. Files will run through all validation programs, but you will not be able to submit and certify the report until the report period is complete.

5. What constitutes an approved file?

   Your data cannot be accepted until it passes all HCAI edit programs as well as the established Error Tolerance Levels (ETL). At that point you may certify your data. When approved, the Report Status message on the Report Dashboard will display *Approved – This report has been submitted and certified, and its data has been approved*.

Early Record Entry

6. Are we able to submit individual records online?

   Yes. After a report period has begun, facilities may choose to enter a record by using the *Enter/Correct* button on the Report Dashboard. Refer to the Quick Guides and training videos on our Training page for more information.

7. What errors does SIERA check for when using early record entry?

   There are two options when adding a record:

   a) Record Listing page
   Each time you enter a record, at the bottom of the page you have the option to either *Validate* or *Save*. *Save* will store the record with no error validation. The *Validate* button runs data through all validation programs.

   b) Record Detail page
   Each time you enter a record, at the bottom of the page you have the option to either *Save* or *Save & Validate* the record. *Save* will store the record with no error validation. The *Save & Validate* button will validate the record only through the Standard Edit program.

   The office may occasionally make edit program updates up until the report period completion date. As a result, you may see new edits that did not appear during earlier validations.

8. Will we be able to enter the information on a daily basis?

   Yes. The system is usually available except during maintenance. You will find changes to system availability noted under “Announcements” on the SIERA Home page. Assistance is only available during supported business hours. (Monday – Friday 8:00-5:00)

Error Tolerance Levels (ETL)

9. Please explain what Error Tolerance Level (ETL) means.

   ETL refers to the percentage of records that may be accepted with an error.
   - ETL for standard edits and readmission edits (IP only) must be 2% or less for each edit program.
   - The report cannot contain any records with a Blank or Invalid Principal Diagnosis.

- The report cannot contain any Critical Trend or Critical Comparative edit flags.

AS Only

- The report cannot contain any record with a blank or invalid Principal Procedure.

Corrections

10. How do I view my data errors?

    Each edit program has a Summary Report which is available on the Report Dashboard. To view individual records to address Trend and Comparative edits, you will need to run custom reports that filter your data. Refer to the Quick Guides and training videos on our Training page for more information.

11. How do I correct my data in SIERA?

    Facilities are responsible for correcting their own data. HCAI will not make corrections to your data. Facilities may correct data in one of two ways:

    1. By making corrections to the data in the facility's system and resubmitting the entire file for processing.
    2. By using the online correction function to manually correct individual records directly in SIERA and then submitting those corrections.

    CAUTION: DO NOT SUBMIT A FILE AFTER SUBMITTING MANUAL CORRECTIONS IN THE SYSTEM! A file submission will overwrite all previous data and corrections you've saved in SIERA. If you need to manually correct or add records in conjunction with a file submission, submit the file first and then complete the data changes in SIERA.

    Refer to the Quick Guides and training videos on our Training page for more information on making data corrections.

12. Do I need to correct all data errors before certifying my data?

    You must correct your data so that they are below the established Error Tolerance Level (ETL) at which point they can be submitted and certified. HCAI encourages you to correct your data to the highest accuracy whenever possible. NOTE: once you have submitted and certified your data report, you will not have the option to make any further corrections or changes to your data.

Extensions and Penalties

13. What is an extension? How do I get one?

    If your data report has not been certified on or before the due date, an extension request must be submitted to avoid penalties. Each report period your facility receives a pool of extension days for each data type. There are 14 extension days available for each report period and each data type.

    An extension is granted when you submit an online extension request.
    You may do so by clicking the Request Extension link found in the top banner of the Home page. Please view the Quick Guide on our Training page for more information.

    If a due date falls on a weekend or holiday, an extension request or an approved formal submission on the next business day will be considered timely. Any penalties accrued will be assessed based on the due date.

14. What are the penalties for late submissions?

    Penalties of $100 per day will be applied for each day after the due date that the data report is not certified or if an extension has not been filed and approved (when extension days are still available).

Assistance

15. Who should I contact if I have a question about SIERA or Patient Level Data?

    SIERA is supported from 8:00 a.m. to 5:00 p.m. PST, Monday through Friday, except for Official State Holidays. Questions specific to Patient Level Data can be directed to:
    Email: PatientLevel@hcai.ca.gov
    Main Line: (916) 326-3935
    Fax: (916) 327-1262

    You may also contact your HCAI analyst during supported hours.

16. What do I do if I have problems submitting my data and getting it approved? (e.g. the system rejects my data due to an edit flag, but the data is correct as reported.)

    HCAI is committed to providing you with the assistance you will need to successfully submit your data. Please call your HCAI analyst who will assist you in evaluating the edits. You also have 24-hour access to our online resources.

Regulations

17. Where can I find the patient data reporting requirements online?

    You will find Title 22 in the California Code of Regulations at https://oal.ca.gov/publications/ccr/ or on the Regulation page of our website.

Data Specific FAQs

Inpatient (IP) Specific FAQs

1. What codes are used for inpatient care?

   For 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.

2. 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”. Do not confuse admission date with service date.

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

   Regulation Section 97213 states that a hospital shall not report a separate ED or AS record if the encounter results in a same-hospital admission. The ED or AS data record must 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. Procedure dates up to 72 hours (3 days) prior to admission will be accepted.

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

4. How should we report an ED or AS encounter that is sent to observation? Do we report services provided in observation to HCAI?

   An ED or AS record must be reported to HCAI 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. When the patient is expected to go home after observation, discharge status on the ED or AS encounter would be *home/routine*.

5. What service date do we report if an ED or AS patient came in on June 30th, stayed overnight, and was sent home 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.

6. 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.

7. Which hospitals must report outpatient surgery procedures?

   California Law, Health & Safety Code 128700 states that hospitals and freestanding licensed ambulatory surgery clinics are required to report to HCAI if they perform procedures on an outpatient basis in:

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

8. For AS encounters, do we need to submit procedure data for every patient that comes to our facility?

   An AS encounter must be reported if these **two criteria are fulfilled**:

   a) Procedure is performed on an outpatient basis, AND
   b) 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.