

# OCCI AUDIT REPORTS REVIEW

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## 4.1 OVERVIEW OF THE AUDIT REPORTS

The OCCI annual data submissions are reviewed for data quality. A series of audits that are based on the OCCI standards are conducted on the annual submission data. The audit results are summarized in audit reports and sent to facilities. The audit report points out records with data quality issues that need to be corrected because they do not comply with case costing standards. Facilities are required to review the audit reports and correct record errors. Records with errors that cannot be corrected must be deleted.

Table 4.1 below provides a listing of each audit criteria and the expectations for passing each criterion. In addition to the OCCI data, CIHI data with patient descriptive details are used to verify that cases submitted to both CIHI and OCCI match. Further details about the OCCI data files are provided in section 4.2. Details of the audit reports for each patient type are provided in sections 4.3.1 to 4.3.5. Audit reports for CCAC clients are currently being developed and details will be provided in section 4.3.6.

**Table 4.1: List of Audit Criteria and Expected Standard for Passing an Audit**

Audit Criteria	Passing Standard
OCCI submitted cases not matched to cases in CIHI database	The purpose of this audit is to ensure that the records submitted can be linked to clinical data from CIHI, which becomes part of the OCCI database.
Cases in CIHI database not matched to OCCI submitted cases	The purpose of this audit is to identify cases in the DAD that were not included in the OCCI submission.
Percentage of distributed operational costs to patients	For first two years of OCCI submission, 80% of total operational costs for all patients. Subsequent years, 95% of total operational for acute inpatient cost must be submitted. 80% of total operational cost for all other patient types. If the above criteria are not met, OCCI submission is not accepted.
Invalid Absorbing-Cost Centres (ACC) Functional Centres (AFC)	All functional centres must be OHRS compliant. Invalid absorbing-cost centres functional centre are not accepted.
Duplicated Functional Centre Cost	One cost per functional centre per service date. Costs in functional centres should be cumulative per service date. Duplicated functional centre costs are deleted.
Percentage of Zero Cost Data by Functional Centre	To be reviewed by facility – for information only.
Details of Zero Cost	Records with zero costs are deleted.
Indirect Cost Ratios by Functional Centre	To be reviewed by facility – for information only
Indirect Cost Ratio Outliers	Functional centres with indirect cost less than 10% or greater than 40% are not accepted.
Low Cost Cases	Case cost of \$100 or less are not accepted. For Ambulatory cases this is <\$5.
High Cost Cases	Case cost of \$1,000,000 are flagged and require rationale/ justification for inclusion.
Missing Nursing Costs	For a Length of Stay (LOS) of 2 or more days, 90% of the total LOS must have nursing costs For a LOS of 2 days or less, 50% of total LOS must have nursing costs
Missing OR Costs	Cases with intervention location code 01, 02, 08, 09 or 10 must

Audit Criteria	Passing Standard
	have costs in functional centres 71260* to 71262, 712502* to 712509000 and 713402* 7134055*, 7*41544 Such cases must also have costs in 71265* , 71262, 71265**, 71362, 71365,71369
Cases with Length of Stay (LOS) >1 day but only 1 Functional Centre with Cost	To be reviewed by facility. Cases with LOS of more than 1 day should have costs in more than 1 functional centre.
Service Dates	Cost with service dates before admit date and after discharge date are deleted with the following exceptions: -1 day prior to admit date and 1 day post discharge date for functional centres 712*, 713* -2 days prior to admit date for functional centre 71440* -Up to 120 days post discharge date for 71410*, 7*415* and 71435* to 71490*(except 71440*)
Variable Direct Supply (VDS) Cost for Wait Time and Priority Services	Hips and Knees with procedure codes 1SQ53*, 1VA53* and 1VG53* should have costs in 71260* or 71262* with minimum VDS cost of \$200.00 Pacemaker with procedure code 1HZ53GRNK should have costs in functional centre 7126042 for inpatient or 7141544 for outpatient with minimum VDS cost of \$500 CMG 175 and 176 for inpatient or CACS 1536 for outpatient should have costs in 7141544 with a minimum VDS cost of \$100 Cataract cases with procedure codes 1CL89VRLM* and 1CL89VRLN* should have cost in 71260 or 71262, 71360, 71362 or 71369 with a minimum VDS cost of \$100

## 4.2 CIHI DATA FILE CUT

Financial data must be combined with patient descriptive data from CIHI data holdings to form the OCCI Submission. CIHI data holdings include the Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS), Continuing Care Reporting System (CCRS), Ontario Mental Health Reporting System (OMHRS) and National Rehabilitation System (NRS). The OCCI and CIHI datasets are merged using a set of key elements specific to each patient population. These key elements are merged in two audits, OCCI cases submitted not matched to CIHI and the cases submitted to CIHI not matched to OCCI submitted cases. All unmatched records appear in the audit reports.

The format of these elements must be identical, including leading zeros, slashes etc. for the merge to be successful and for records to match. For example, the data element Chart Number would produce an unmatched record if the OCCI data is 00999999 and the CIHI data is 0000999999. Each facility must internally validate the formats of both the costing information and the CIHI data holdings.

The MOHLTC provides a data file to each hospital with the key elements from CIHI that are used in merging. The CIHI file serves to show the data format required. See table 4.2 below for the layout of the CIHI cut text file indicating the data type (string or date), starting position of the data element, length of the data element and the element ID.

Note: For Acute Inpatient and Ambulatory patient types, the most current grouper/classification will be indicated for Fiscal Year 2009/10. For example, the inpatient audit report shows CMG Plus.

**Table 4.2: Format of the CIHI Data Elements**

Note: \* Date data in format YYYYMMDD

DAD Data Elements	Data Type (S=String, D=Date*)	Start Position	Data Length	Element ID
Institution Number	S	1	5	101
Chart Number	S	20	10	109
Register Number	S	30	7	110
Admit Date	D	113	8	401

NACRS Data Elements				
Institution Number	S	4	5	00B
Chart Number	S	24	10	1
Ambulatory Registration Number	S	74	12	11
MIS code	S	89	9	13
Registration Date	D	116	8	27

CCRS Data Element				
Unique Registration Number	S	1	20	AA1
Facility Number	S	25	5	AA6
Health Record Number	S	35	12	A6a
Admission date	D	45	8	AB1

OMHRS Data Element				
Chart Number	S	17	12	X30
Case Record Number	S	29	12	AA3
Institution Number	S	41	5	AA4
Admit Date	D	50	8	CC1

NRS Data Element				
INST NUMBER	S	1	5	1A
Chart Number	S	10	10	4
Admission Date	D	25	8	21

### 4.3 AUDIT REPORTS BY PATIENT/CLIENT SERVICE TYPE

Audit reports are available for hospitals by patient service type and are described in detail in sections 4.3.1 to 4.3.5. Since CCACs are participating in the OCCI beginning in 2009/10, the audit reports still need to be defined.

Below is a list of definitions for terms used in audit reports

- The Length of Stay field is calculated based on the admission and discharge dates.
- The Direct Cost is the sum of all direct costs (cost components VDL, VDMGS, VDMPS, VDO, FDL, FDO, FDBEG). For a description of these direct costs components refer to OCCI Submission Technical Specification version 7.0, section 5.0 –Financial Costing Data
- The Indirect Cost is the sum of variable indirect cost and fixed indirect cost.
- The Total Cost is the sum of direct and indirect costs.
- Under the Keep/Delete column heading, the default is set as “Delete”. The facility must enter the request to keep or delete this record from the OCCI database.

#### 4.3.1 HOSPITAL ACUTE INPATIENT

For the first year of case costing, a minimum of 80% of acute inpatient operating costs must be distributed to patients.

Additional functional centres must be costed so that by the beginning of the third year of costing and onwards, at least 95% of inpatient costs are distributed to patients.

**Table 4.3: Mandatory Functional Centres to be Distributed/Costed for All Patient types**

Functional Centre Number	Functional Centre Name
712**** to 7127****	Nursing Inpatient Services (IP)
71410**	LAB Clinical Laboratory
71415**	DI Diagnostic Imaging
71440**	PH Pharmacy

##### 4.3.1.1 OCCI submitted cases not matched to cases in CIHI database

This audit matches the submitted OCCI records to additional clinical data from the DAD based on a specified set of key elements. The purpose of this audit is to ensure that the records submitted can be linked to clinical data from CIHI, which becomes part of the OCCI database. Records submitted that do not match are listed in the report. The matching criterion is the master number, chart number, registration number and admission date. If these are not corrected the cases are excluded from the submission. The report has the following column headings:

- (A) Master #
- (B) Chart #
- (C) Register #
- (D) Admission Date
- (E) Discharge Date
- (F) Total Direct Cost
- (G) Total Indirect Cost

#### **4.3.1.2 Cases in CIHI database not matched to OCCI submitted cases**

The purpose of this audit is to identify cases in the DAD that were not included in the OCCI submission. If a case in the DAD cannot be matched to a submitted case, it is listed in the report.. **Note that stillbirth records are excluded.** This report may include cases from audit 1 (described in section 4.3.1.1) and follows the same matching criterion. **If not corrected, all cases are excluded from the submission.** The report has the following column headings:

- (A) Master #
- (B) Chart #
- (C) Register #
- (D) Admission Date
- (E) Discharge Date

#### **4.3.1.3 Invalid Absorbing ~~Cost Centres (ACC)~~ Functional Centres (AFC)**

The purpose of this audit report is to ensure that costed records have valid functional centres. **Absorbing Cost Centres** ~~Absorbing Functional Centres~~ are generally the patient care areas. A list of valid **ACC AFCs** for acute inpatient is included in **Appendix A1/A2**. The list is based on the Ontario Healthcare Reporting Standards (OHRS) version **7.0**. Any cost record with a functional centre that is not listed in the **Appendix A1/A2** is shown in this report. **If these are not corrected, the record(s) are deleted.** The report has the following column headings:

- (A) Functional Centres
- (B) # of Records
- (C) Percent %
- (D) Correct ~~ACC~~ **AFC**

#### **4.3.1.4 Duplicated Functional Centre Cost**

Each case is defined by a unique encounter number (also referred to as account number or registration number). Each case would have the same or equal Master number, chart number, encounter number and admission date. This audit checks for duplicated functional centres and corresponding registration numbers and service dates.

Costs in the same functional centre should be rolled up. **If these are not corrected, the record(s) are deleted.** The report has the following column headings:

- (A) OCCI Identifier
- (B) Master #
- (C) Chart #
- (D) Register #
- (E) Admission Date
- (F) Service Date
- (G) Functional Centre
- (H) Direct Cost
- (I) Indirect Cost
- (J) Keep/Delete
- (K) Reason to Keep

#### **4.3.1.5 Percentage of Zero Cost Data by Functional Centre**

This audit report identifies all functional centres in the submission where the direct or indirect costs appear as \$0. Unless a cost is below \$1.00 as a result of rounding down, no functional centre should be reported with a cost of \$0. **If these are not corrected, the record(s) are deleted.** The report has the following column headings:

- (A) Master #
- (B) Functional Centre
- (C) # of Records
- (D) Mean Direct Cost
- (E) Mean Indirect Cost
- (F) # of \$0 Direct Cost Records
- (G) # of \$0 Indirect Cost Records
- (H) \$0 Direct Cost Records Percent
- (I) \$0 Indirect Cost Records Percent

This audit report also includes negative costs, except when the negative costs are in functional centre 7144\* (Pharmacy). Negative costs are allowed in the Pharmacy functional centre to accommodate for crediting drug returns.

The Indirect Cost (G) is the sum of variable indirect cost and fixed indirect cost:  
( $G=VI$  cost component +  $FI$  cost component).

The \$0 Direct Cost Records percentage is calculated by:  
the number of \$0 Direct Cost Records divided by total number of records with zero cost in the same functional centre, multiplied by 100 and rounded to one decimal place.  $H = 100 * F / C$

The \$0 Indirect Cost Records percentage is calculated by:  
the number of \$0 Indirect Cost Records divided by total number of records with zero cost in the same functional centre, multiplied by 100 and rounded to one decimal place.  $I = 100 * G / C$

#### **4.3.1.6 Details of Zero Costs**

This audit report identifies records with \$0 direct or \$0 indirect cost. If these are not corrected, the record(s) are deleted. The report has the following column headings:

- (A) OCCI Identifier
- (B) Master #
- (C) Chart #
- (D) Registration #
- (E) Admission Date
- (F) Service Date
- (G) Functional Centre
- (H) Direct Cost
- (I) Indirect Cost
- (J) Keep/Delete
- (K) Reason to Keep

#### **4.3.1.7 Zero total cost**

The purpose of this audit report is to identify records submitted that have zero cost. If the total of direct and indirect cost is zero, the records are listed in the report. **Further investigation by the facility is required otherwise these records will be deleted.** The report has the following column headings:

- (A) OCCI Identifier
- (B) Master #
- (C) Functional Centre
- (D) Chart #
- (E) Registration #
- (F) Admission Date
- (G) # of Records

#### **4.3.1.8 Indirect Cost Ratios by Functional Centre**

The trend of indirect cost percentage is examined here for rationality and consistency. Extreme relative fluctuations (e.g. indirect cost of 40% for one lab centre and 10% for another) would need to be rationalized. Questionable indirect cost ratios indicate that indirect costs may not have been properly assigned to the functional centres by SEAM, e.g. allocation statistics may have been input incorrectly. The report has the following column headings:

- (A) Master #
- (B) Functional Centre
- (C) # of Records
- (D) Direct Cost
- (E) Indirect Cost
- (F) Total Cost
- (G) Indirect Cost Ratio

The Indirect Cost Ratio is calculated by taking the indirect cost of each functional centre divided by the Total Cost of the functional centre, multiplied by 100. The Indirect Cost Ratio is displayed with 3 decimal places.

#### **4.3.1.9 Indirect Cost Ratio Outliers**

The Indirect Cost Ratio is acceptable if it falls within the range of 10% to 40%. Based on the Indirect Cost Ratios by Functional Centre (Audit # 8, section 4.3.1.8), this audit report itemizes each functional centre with indirect cost ratios below 10% or higher than 40%.

Under the Comment column heading, the facility must enter a comment to explain/justify why indirect cost ratios do not meet the standard range. The report has the following column headings:

- (A) Master #
- (B) Functional Centre
- (C) # of Records
- (D) Direct Cost
- (E) Indirect Cost
- (F) Total Cost
- (G) Indirect Cost Ratio
- (H) Comment

#### **4.3.1.10 Low Cost/High Cost Cases**

This audit report identifies cases with total cost of less than \$100 or more than \$1,000,000 and all cases with more than two days of LOS having total costs of \$100 and less. **If not corrected, all cases are deleted.**

- Under the Reason for Keep column heading, the facility must enter a comment to explain/justify why the case is low cost. For example, patient total LOS is only 10 minutes, patient transferred.
- **Any cases with total costs of \$1,000,000 are included in the audit report. The facility must review each case to determine legitimacy of costs prior to inclusion to the OCCI database.**

This audit report also identifies all cases with total costs of \$1,000,000 and over. The hospital needs to review the legitimacy of costs incurred by the patient.

The rationale is that in most cases, extreme high costs are likely due to two types of errors:

- invalid product/service utilization information used for assigning costs and/or
- invalid calculation of unit costs.

The report has the following column headings:

- (A) OCCI Identifier
- (B) Master #
- (C) Chart #
- (D) Registration #
- (E) Admission Date
- (F) Length of Stay
- (G) In-Id CMG+
- (H) CIHI CMG+
- (I) Level
- (J) Main Diagnosis
- (K) Primary Intervention
- (L) Direct Cost
- (M) Indirect Cost
- (N) Total Cost
- (O) Reason for Delete
- (P) Keep/Delete
- (R) Reason for Keep

#### **4.3.1.11 Missing Nursing Costs**

For any cases with LOS of two or more days, nursing costs must be reported for a minimum of 90% of the patient's time in hospital. Due to nursing shifts that include two calendar days, nursing costs may be omitted from the admit day and reported on the second day of stay. Conversely, nursing costs may be reported 1 day prior to admission date or 1 day after discharge date.

For any cases with LOS of two days or less, nursing costs can be reported for a minimum of 50% of the patient's time in hospital. It is acceptable to report only 1 day of nursing costs out of the two days. Nursing costs are identified from the variable direct labour costs. Nursing costs must be reported for each day of stay, excluding the admit date, for the following functional centres:

- from 712100000 to 71270\*;
- from 713400000 to 713500000; and
- 71310\*\*.

A list of cases which do not have nursing costs for each day of stay are identified. Cases with LOS of more than 2 days are identified and have less than 90% of nursing costs, as compared to their LOS excluding the admit and discharge dates, are also identified. Cases with LOS of less than 2 days must have nursing costs in at least one service date (50% standard). A subtotal should be developed per case that indicates the number of service dates without nursing costs (x). A percentage can be calculated by taking x divided by total LOS, multiplied by 100. The percentage must meet the 90% standard.

Otherwise, the case is deleted.

The LOS field is calculated based on admission and discharge dates.

The report has the following column headings:

- (A) OCCI Identifier
- (B) Master #
- (C) Chart #
- (D) Registration #
- (E) Admission Date
- (F) Discharge Date
- (G) Length of Stay
- (H) CIHI CMG+
- (I) Service Date
- (J) Reason for Possible Deletion
- (K) Keep/Delete
- (L) Reason for Keep

#### 4.3.1.12 Missing Operating Room (OR) Costs

There are two audit steps which identify missing OR costs. In the first audit step, cases that are missing OR costs are identified by selecting all patients who have had an intervention location code with 01,02,08,09 or 10. Table 4.4 indicates the intervention location and functional centre numbers associated with each intervention location code.

**Table 4.4: Functional Centre Number, Intervention Location associated with each Intervention Location Code**

Intervention Location Code	Intervention Location	Functional Centre Number
01	Main operating room	71260**, 71262
02	Endoscopic Room (includes GI Unit)	7134055
08	Cardiac Catheterization Lab	7141544
09	Ambulatory OR	71360, 71362, 71369
10	Obstetrics Case Room/Delivery Room/OR	712502* (excluding 7125080* Nursery)

The cases with OR costs must have costs in the following functional centres:

- 71260\* to 71262\*
- 71360, 71362, 71369
- 7134055\*
- 712502\* to 712509000

Cases that do not match to the Intervention Location Code are identified as missing OR costs.

In the second audit step, a list of all cases with assigned recovery room costs is matched to all cases with OR costs. Cases with recovery room costs but no OR costs are identified. Recovery room costs are reported under functional centre 712502040 for any cases with Intervention Location code 10. For all other cases, recovery room costs could be reported in 71265\*, ~~7\*34020 or 7\*34025\*~~, 71362, 71365, or 71369.

All records with missing OR costs must be examined to determine if there are any issues related to the capture of data (especially if capture is manual), the interface of data to the costing system and/or costing of patients in the costing system itself. If not corrected, all cases are deleted.

The report has the following column headings:

- (A) OCCI Identifier
- (B) Master #
- (C) Chart #
- (D) Registration #
- (E) Admission Date
- (F) Length of Stay
- (G) CIHI CMG+
- (H) Procedure Location
- (I) Reason for Possible Deletion
- (J) Keep/Delete
- (K) Reason to Keep

#### ***4.3.1.13 Cases with Length of Stay >1 day but only 1 Functional Centre with costs***

This audit report identifies cases that may be missing costs. The case identified with a LOS greater than one day but costs from only one functional centre are provided. The rationale is that in most instances, cases with a LOS greater than one day should have costs from more than one functional centre. The hospital should examine these cases to ensure that all utilization/workload is being captured and that there are no issues with the interface of data to the costing system. If not corrected, all cases are deleted.

The Length of Stay field is calculated based on admit and discharge dates. The report has the following column headings:

- (A) OCCI Identifier
- (B) Master #
- (C) Chart #
- (D) Registration #
- (E) Admission Date
- (F) Functional Centre
- (G) Length of Stay
- (H) CIHI CMG+
- (I) Keep/Delete
- (J) Reason to Keep

#### ***4.3.1.14 Service Dates***

This audit report identifies all cases which contain pre-admit or post-discharge records. Records are identified excluding the exceptions noted below:

- 1 day prior to the admit date and 1 day post discharge date for 712\* and 713\* functional centres, as workload could be recorded the day prior to the admit date due to the nursing shifts.
- 2 days prior to admit date for functional centre 7144\*.
- Up to 120 days following the discharge date for 71410\*, 71415\* and 71435\* to 71490\*, as some facilities record the date of service as the result date. In addition, the 30 days following the discharge date are included due to the recording of pharmacy credits.

All records identified with dates of service pre-admit or post-discharge should be examined to determine if there are any issues related to the capture of data, to ensure that the costs recorded are for services consumed by the patient. The report has the following column headings:

- (A) OCCI Identifier
- (B) Master #
- (C) Chart #
- (D) Registration #
- (E) Admission Date
- (F) Discharge Date
- (G) Service Date
- (H) Functional Centre
- (I) Direct Cost
- (J) Indirect Cost
- (K) Reason for Deletion
- (L) Keep/Delete
- (M) Reason for Keep

#### 4.3.1.15 Variable Direct Supply Cost for Wait Time and Priority Services

This audit . The first audit step checks that each of the procedures listed below has a corresponding variable direct supply cost in the correct functional centre. The second audit step checks for the minimum cost of the variable direct supply. The reports identify cases with low variable direct supply costs. The variable direct supply cost for these cases cannot be lower than the Wait Time and Priority Program Funding Rates. If not corrected, all cases are deleted.

Table 4.5 describes each procedure code and the minimum cost for variable direct supply cost:

**Table 4.5: Procedures for Acute Inpatient Wait time and Priority Services**

Procedure Code	Functional Centre	Minimum Variable Direct Supply Cost
Hips and Knees cases with procedure code 1SQ53*, 1VA53* and 1VG53* except 1VA53LASLN and 1VG53LASLN	71260* or 71262*	\$ 200.00
Pacemaker cases with procedure codes 1HZ53GRNK	7126042	\$ 500.00
Cardiac Catheterization Lab cost should be included for CMG+ 175 (PCI w MI/Shock/Arrest/Hrt Fail) and 176 (PCI wo MI/Shock/Arrest/Hrt Fail)	7*41544	\$ 100.00

The report has the following column headings:

- (A) OCCI Identifier
- (B) Master #
- (C) Chart #
- (D) Registration #
- (E) Admission Date
- (F) Functional Centre
- (G) Procedure Code
- (H) Direct Supplies (Patient Specific)
- (I) Variable Direct Supplies (General)
- (J) Reason for Delete
- (K) Keep/Delete
- (L) Reason for Keep

### 4.3.2 HOSPITAL AMBULATORY CARE

Ambulatory care services refer to the functional centres listed in Table 4.6. A minimum of 80% of ambulatory care operating costs must be distributed to patients.

**Table 4.6: Mandatory Functional Centres to be Distributed/Costed for Ambulatory Care Service**

Functional Centre Number	Functional Centre Name
71310**	AC Emergency (ER)
71340**	AC Specialty Day/Night Care
71360	Day Surgery Operating Room
71362	Day Surgery Combined OR& PARR
71367	Day Surgery Post-Anesthetic Recovery Room
71369	Day Surgery Pre and Post Operative Care
7134055	AC Day/Night Care-Endoscopy
713501070	AC Clinic Medical – Pre-Admission
713501545	AC Clinic Surgical – Pre-Admission
71410**	LAB Clinical Laboratory
71415**	DI Diagnostic Imaging
71430**	NV Non-Invasive Cardiology and Vascular Laboratories
71440**	PH Pharmacy
71450	TH Physiotherapy
71455**	TH Occupational Therapy
71470**	TH Social Work
71435	TH Respiratory Therapy

#### 4.3.2.1 OCCI submitted cases not matched to cases in CIHI database

This is the same as the Acute Inpatient audit report (refer to section 4.3.1.1) except records are matched to the NACRS database. The matching criteria are the master number, chart number, registration number, visit **MIS** **OHRS** functional centre and registration date.

#### **4.3.2.2 Cases in CIHI database not matched to OCCI submitted cases**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.2) except cases are matched to the NACRS database. The report has the following column headings

- (A) Master #
- (B) Chart #
- (C) Register #
- (D) Admission Date
- (E) Discharge Date
- (F) **MIS OHRS** Visit Functional Centre

#### **4.3.2.3 Invalid Absorbing **Cost Centres (ACC)** Functional Centres (AFC)**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.3) but based on a valid listing of **AFC in Appendix A**.

#### **4.3.2.4 Duplicated Functional Centre Cost**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.4)

#### **4.3.2.5 Percentage of Zero Cost Data by Functional Centre**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.5)

#### **4.3.2.6 Details of Zero Costs**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.6)

#### **4.3.2.7 Zero total cost**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.7)

#### **4.3.2.8 Indirect Cost Ratios by Functional Centre**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.8)

#### **4.3.2.9 Indirect Cost Ratio Outliers**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.9)

#### **4.3.2.10 Low Cost/High Cost Cases - Cases with Total Cost of < \$5 or > \$1,000,000**

This audit report identifies all cases that have total costs of \$5 or less and all cases with total costs of \$1,000,000 or over. The facility must review high cost cases. The report has the following column headings:

- A) OCCI Identifier
- (B) Master #
- (C) Chart #
- (D) Registration #
- (E) Admission Date
- (F) Hospital CACS
- (G) CIHI CACS
- (H) Main Diagnosis

- (I) Primary Intervention
- (J) Direct Cost
- (K) Indirect Cost
- (L) Total Cost
- (M) Keep/Delete
- (N) Reason for Keep
- (O) Reason

#### 4.3.2.11 Cases or Visits with Missing Nursing Cost

This audit report reviews cases or visits in Day Surgery, Operating Room, Emergency Department, Oncology, Renal Dialysis and Cardiac Catheterization functional centres that are missing nursing costs. **Specific audits will be generated for each of the sections identified in Table 4.7.**

Due to nursing shifts that include two calendar days, nursing costs may be reported on the second day of stay. Nursing costs are identified from the variable direct labour costs and must be reported for each visit for the following functional centres:

**Table 4.7: Ambulatory Care Functional Centres Requiring Nursing Costs if Visits Reported**

<b>Surgical D/N</b>	
7*34020	AC Day/Night Care Pre & Post Operative Care (OR/PARR Excl.)
7*34025*	AC Day/Night Care Surgical/proc (OR/PARR Incl.)
7134055	AC Day/Night Care-Endoscopy
71260**	IP Operating Room
71262	IP OR/PARR Combined
71265**	IP Post-Anesthetic Recovery Rooms (PARR)
71310*	AC Emergency (ER) (only if surgical D/N care services provided by this FC)
71360	Day Surgery Operating Room
71362	Day Surgery Combined OR& PARR
71365	Day Surgery Post-Anesthetic Recovery Room
71367	Day Surgery Pre and Post Operative Care
71369	Day Surgery Combined OR, PARR & Pre and Post Care
<b>Renal Dialysis</b>	
713408610	AC Day/Night Care - Hemodialysis
713408620	AC Day/Night Care - Home Dialysis (Teaching) Comb.
713408630	AC Day/Night Care - Home Hemodialysis (Teaching)
713408640	AC Day/Night Care - Home Peritoneal Dial.(Teaching)
713408650	AC Day/Night Care - Peritoneal Dialysis
713408660	AC Day/Night Care - Self-Care Hemodialysis
7153086	COM Dialysis Home Care
<b>Cancer Care</b>	
7134066	AC Day/Night Care – Oncology
713406610	AC Day/Night Care - Oncology – Chemotherapy
713406620	AC Day/Night Care - Oncology – Other Supportive Therapy
71466	RAD Radiation Oncology
7146610	RAD Treatment Planning
7146620	RAD Mould Room
7146630	RAD Treatment
713506605	AC Clinic Oncology – Systemic – Pre and Post Treatment

713506615	AC Clinic Oncology – Radiation – Pre and Post Treatment
713506620	AC Clinic Oncology – Surgical – Pre and Post Treatment
713506630	AC Clinic Oncology – Combined
7153066	COM Oncology Home Care
715106610	COM Oncology Treatment Outreach Clinic
715106620	COM Oncology Preventative Clinics
<b>Cardiac Catheterization</b>	
7141544	DI Cardiac Catheterization Lab
714154410	DI Cardiac Catheterization Interventional
714154420	DI Cardiac Catheterization Diagnostic Services
<b>Emergency</b>	
7131020	AC Emergency – General
7131022	AC Emergency – Alternate Funding
7131025	AC Emergency – Hospital Urgent Care Centre
7131028	AC Emergency – Trauma
7131040	AC Emergency – Interim Assessment/Clinical Decision Unit
7131076	AC Emergency – Psychiatric Services/Crisis Intervention

The report has the following column headings:

- (A) OCCI Identifier
- (B) Master #
- (C) Registration #
- (D) Chart #
- (E) Admission Date
- (F) CIHI CACS
- (G) Functional Centre
- (H) Direct Cost
- (I) Indirect Cost
- (J) Keep/Delete
- (K) Reason for Keep

#### **4.3.2.12 Service Dates**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.12)

#### **4.3.2.13 Minimum cost for Priority Services**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.13)

#### **4.3.2.14 Missing Operating Room (OR) Costs**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.14)

#### **4.3.2.15 Variable Direct Supply Cost for Wait Time and Priority Services**

This audit produces two reports. The first report checks that each of the procedures listed in Table 4.8 has a corresponding variable direct supply cost in the correct functional centre. The second audit report checks for the minimum cost of the variable direct supply. Cases with low variable direct supply costs are identified and cannot be lower than the Wait Time and Priority Program Funding Rates. Table 4.8 describes each procedure code and the minimum cost for variable direct supply cost:

**Table 4.8: Procedures for Ambulatory Care Wait time and Priority Services**

Procedure Code	Functional Centre	Minimum Variable Direct Supply Cost
Pacemaker cases with procedure code 1HZ53GRNK	71260 or 71262 or 7136*	\$ 500.00
Cataract cases in Day Surgery with procedure codes 1CL89VRLM* and 1CL89VRLN*	71260** or 71262 for outpatient 7136* 7134025** or 7*34055	\$ 100.00
Cath lab cost should be included for CACS 1536 (Other Cardiac Intervention – Percutaneous transluminal Approach	7141544	\$ 100.00

**Audit Report 1:** Cases without costs in the Correct Functional Centre have the following column headings:

- (A) Master #
- (B) Chart #
- (C) Admission Date
- (D) CIHI Grouper
- (E) Primary Procedure
- (F) CIHI CACS
- (G) Functional Centre

**Audit Report 2:** Cases with Variable Direct Supply Cost less than minimum for certain procedures have the following column headings:

- (A) Master #
- (B) Chart #
- (C) Encounter #
- (D) Admission Date
- (E) Discharge Date
- (F) Service Date
- (G) Functional Centre
- (H) Direct Cost
- (I) Indirect Cost
- (J) CIHI Grouper
- (K) Primary Procedure

### 4.3.3 HOSPITAL MENTAL HEALTH INPATIENT

Functional centres applicable to mental health inpatients are listed in Table 4.9. A minimum of 80% of mental health operating costs must be distributed to patients.

**Table 4.9: Mandatory Functional Centres to be Distributed/Costed for Mental Health**

Functional Centre Number	Functional Centre Name
71276**	IP Mental Health / Addictions
71410**	LAB Clinical Laboratory
71415**	DI Diagnostic Imaging
71430**	NV Non-Invasive Cardiology and Vascular Laboratories
71440**	PH Pharmacy
71470*	TH Social Work

#### ***4.3.3.1 OCCI submitted cases not matched to cases in CIHI database***

This is the same as Acute Inpatient audit report (refer to section 4.3.1.1) except records are matched to the OMHRS database. The matching criterion is the master number, chart number, case record number and admission date.

#### ***4.3.3.2 Cases in CIHI database not matched to OCCI submitted cases***

This is the same as Acute Inpatient audit report (refer to section 4.3.1.2) except cases are matched to the OMHRS database.

#### ***4.3.3.3 Invalid Absorbing ~~Cost Centres (ACC)~~ Functional Centres (AFC)***

This is the same as Acute Inpatient audit report (refer to section 4.3.1.3). Applicable ACCs AFCs start with 71276.

#### ***4.3.3.4 Duplicated Functional Centre Cost***

This is the same as Acute Inpatient audit report (refer to section 4.3.1.4)

#### ***4.3.3.5 Percentage of Zero Cost Data by Functional Centre***

This is the same as Acute Inpatient audit report (refer to section 4.3.1.5)

#### ***4.3.3.6 Details of Zero Costs***

This is the same as Acute Inpatient audit report (refer to section 4.3.1.6)

#### ***4.3.3.7 Zero total cost***

This is the same as Acute Inpatient audit report (refer to section 4.3.1.7)

#### ***4.3.3.8 Indirect Cost Ratios by Functional Centre***

This is the same as Acute Inpatient audit report (refer to section 4.3.1.8)

#### ***4.3.3.9 Indirect Cost Ratio Outliers***

This is the same as Acute Inpatient audit report (refer to section 4.3.1.9)

#### ***4.3.3.10 Low Cost/High Cost Cases - Cases with Total Cost of < \$100 or> \$1,000,000***

This audit report identifies all cases with more than one day of length of stay that have total costs of \$100 and less and all cases with total costs of \$1,000,000 and over. The facility must review high cost cases. The report has the following column headings:

(A) Master #

- (B) OCCI Identifier
- (C) Chart #
- (D) Registration #
- (E) Admission Date
- (F) Length of Stay
- (G) Direct Cost
- (H) Indirect Cost
- (I) Total Cost
- (J) Keep/Delete
- (K) Reason for Keep
- (L) Reason

#### 4.3.3.11 Missing Nursing and/or Allied Health Costs

This audit report looks at each case and determines for each service date that, there is a variable direct labour cost either in nursing or in allied health functional centres. If the nursing cost is missing and there are allied health costs for the same service date, the record is accepted.

**For any cases with LOS of two or more days**, nursing and/or allied health costs must be reported for a minimum of 90% of the patient's time in hospital. Due to varying clinical shifts that include two calendar days, nursing or allied health costs may be omitted from the admit day and reported on the second day of stay. Conversely, nursing or allied health costs may be reported 1 day prior to admission date or 1 day after discharge date.

**For any cases with LOS of two days or less**, nursing or allied health costs can be reported for a minimum of 50% of the patient's time in hospital. It is acceptable to report only 1 day of nursing or allied health costs out of the two days.

The nursing functional centres for Mental Health inpatients are 71276\*\*.

The allied health functional centres are provided in Table 4.10.

**Table 4.10: Allied Health Functional Centres**

Functional Centre Number	Functional Centre Name
7* 4 44	TH Combined Therapeutics
7* 4 45	TH Clinical Nutrition
7* 4 50	TH Physiotherapy
7* 4 55	TH Occupational Therapy
7* 4 60	TH Audiology & Speech/Language Pathology
7* 4 65	TH Rehabilitation Engineering
7* 4 70	TH Social Work
7* 4 72	TH Addiction Counselors
7* 4 74	TH Genetics Counselling
7* 4 75	TH Psychology and Psychometry
7* 4 80	TH Pastoral Care
7* 4 85	TH Therapeutic Recreation
7* 4 90	TH Child Life
7*435	TH Respiratory Therapy (incl. Pulmonary Function)

A list of all cases missing nursing or allied health costs for each day of stay is identified for each case and compared to the LOS for the case. Cases with LOS of more than 2 days and have less than 90% of

nursing or allied health costs as compared to their LOS, excluding the admit and discharge dates, are identified. Cases with LOS of less than 2 days must have nursing or allied health costs in at least one service date (50% standard). A subtotal should be developed per case that indicates the number of service dates without nursing or allied health costs (x). A percentage should be calculated by taking x divided by total LOS, then multiplied by 100. The percentage must meet the 90% standard. Otherwise, the whole case is deleted.

It is acceptable to report no nursing or allied health costs if a patient had a service interruption.

The report has the following column headings

- (A) OCCI Identifier
- (B) Master #
- (C) Registration #
- (D) Chart #
- (E) Admission Date
- (F) Discharge Date
- (G) Length of Stay
- (H) Service Date
- (I) Direct Cost
- (J) Indirect Cost
- (K) Reason for Possible Deletion
- (L) Keep/Delete
- (M) Reason for Keep

#### **4.3.3.12 Service Dates**

This audit report identifies all cases which contain pre-admit or post-discharge records. Records are identified with the following exceptions:

- 1 day prior to the admit date and 1 day post discharge date for 712 and 713 functional centres, as workload could be recorded the day prior to the admit date due to the nursing shifts.
- 2 days prior to admit date for functional centre 7144\*.
- Up to 120 days following the discharge date for 71410\*, 71415\* and 71435\* to 71490\*, since some facilities record the date of service as the result date. In addition, the 30 days following the discharge date are included due to the recording of pharmacy credits.

All records identified with dates of service pre-admit or post-discharge should be examined to determine if there are any issues related to the capture of data, to ensure that the costs recorded were for services consumed by the patient.

The report has the following column headings:

- (A) OCCI Identifier
- (B) Master #
- (C) Chart #
- (D) Registration #
- (E) Admission Date
- (F) Discharge Date
- (G) Service Date
- (H) Functional Centre
- (I) Direct Cost
- (J) Indirect Cost
- (K) Reason for Deletion
- (L) Keep/Delete
- (M) Reason for Keep

### 4.3.4 HOSPITAL REHABILITATION INPATIENTS

Functional centres applicable to rehabilitation inpatients are listed in Table 4.11. A minimum of 80% of rehabilitation operating costs must be distributed to patients

**Table 4.11: Mandatory Functional Centres to be Distributed/Costed for Rehabilitation**

Functional Centre Number	Functional Centre Name
71281**	IP Rehabilitation
71450	TH Physiotherapy
71455**	TH Occupational Therapy
71470**	TH Social Work

#### 4.3.4.1 OCCI submitted cases not matched to cases in CIHI

This is the same as Acute Inpatient audit report (refer to section 4.3.1.1) except cases are matched to the NRS database

#### 4.3.4.2 Cases in CIHI database not matched to OCCI submitted cases

This is the same as Acute Inpatient audit report (refer to section 4.3.1.2) except cases are matched to the NRS database

#### 4.3.4.3 Invalid Absorbing ~~Cost Centres (ACC)~~ Functional Centres (AFC)

This is the same as Acute Inpatient audit report (refer to section 4.3.1.3). However, for hospital Rehabilitation inpatients, 71281 is the nursing functional centre applicable as ACC AFC.

#### 4.3.4.4 Duplicated Functional Centre Cost

This is the same as Acute Inpatient audit report (refer to section 4.3.1.4)

#### 4.3.4.5 Percentage of Zero Cost Data by Functional Centre

This is the same as Acute Inpatient audit report (refer to section 4.3.1.5)

#### 4.3.4.6 Details of Zero Costs

This is the same as Acute Inpatient audit report (refer to section 4.3.1.6)

#### 4.3.4.7 Zero total cost

This is the same as Acute Inpatient audit report (refer to section 4.3.1.7)

#### 4.3.4.8 Indirect Cost Ratios by Functional Centre

This is the same as Acute Inpatient audit report (refer to section 4.3.1.8)

#### 4.3.4.9 Indirect Cost Ratio Outliers

This is the same as Acute Inpatient audit report (refer to section 4.3.1.9)

**4.3.4.10 Low Cost/High Cost Cases - Cases with Total Cost of < \$100 or > \$1,000,000**

This audit report identifies all cases with LOS of more than one day that have total costs of \$100 and less and all cases with total costs of \$1,000,000 and over. The facility must review high cost cases.

The report has the following column headings:

- (A) Master #
- (B) OCCI Identifier
- (C) Chart #
- (D) Registration #
- (E) Admission Date
- (F) Length of Stay within Fiscal Year
- (G) Direct Cost
- (H) Indirect Cost
- (I) Total Cost
- (J) Keep/Delete
- (K) Reason for Keep
- (L) Reason

**4.3.4.11 Nursing and or Allied Health Costs**

This is the same as Mental Health audit report (refer to section 4.3.3.11)

**4.3.4.12 Service Dates**

This is the same as Mental Health audit report (refer to section 4.3.3.12)

**4.3.5 HOSPITAL COMPLEX CONTINUING CARE INPATIENT**

Functional centres applicable to complex continuing care inpatients are listed in Table 4.12. A minimum of 80% of complex continuing care operating costs must be distributed to patients. The CCRS database from CIHI is the source for inpatient descriptive data.

**Table 4.12: Mandatory Functional Centres to be Distributed/Costed for Complex Continuing Care**

Functional Centre Number	Functional Centre Name
71295**	IP Long Term Care
71450	TH Physiotherapy
71455**	TH Occupational Therapy
71470**	TH Social Work

If the facility's calculated percentage (based on the mandatory and planned functional centre costs to be distributed) is below the minimum, the facility is required to distribute the costs of additional functional centres until the minimum requirement is met.

If the minimum standards described above are not met, the submission is not accepted.

If the facility meets the minimum standards, the series of audits described in sections 4.3.5.1 to 4.3.5.12 are performed. Records that cannot be corrected are deleted from the submission and excluded from the OCCI database.

#### **4.5.1 OCCI submitted cases not matched to cases in CIHI database**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.1) except records are matched to the CCRS database. The matching criterion is the master number, resident code, health record number, and entry date.

#### **4.5.2 Cases in CIHI database not matched to OCCI submitted cases**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.2) except cases are matched to the CCRS database.

#### **4.5.3 Invalid Absorbing ~~Cost Centres (ACC)~~ Functional Centres (AFC)**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.3). However, for Complex Continuing Care, the 71295 is the nursing functional centre applicable as ~~ACC~~, AFC..

#### **4.3.5.4 Duplicated Functional Centre Cost**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.4)

#### **4.3.5.5 Percentage of Zero Cost Data by Functional Centre**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.5)

#### **4.3.5.6 Details of Zero Costs**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.6)

#### **4.3.5.7 Zero total cost**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.7)

#### **4.3.5.8 Indirect Cost Ratios by Functional Centre**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.8)

#### **4.3.5.9 Indirect Cost Ratio Outliers**

This is the same as Acute Inpatient audit report (refer to section 4.3.1.9)

#### **4.3.5.10 Cases with Total Cost of less than \$100 or more than \$1,000,000**

This audit report identifies all cases with more than one day for LOS with total costs of \$100 and less and all cases with total costs of \$1,000,000 and over. The facility must review high cost cases.

The report has the following column headings:

- (A) Master #
- (B) OCCI Identifier
- (C) Chart #
- (D) Registration #
- (E) Admission Date
- (F) Length of Stay within Fiscal Year
- (G) Direct Cost
- (H) Indirect Cost
- (I) Total Cost
- (J) Keep/Delete
- (K) Reason for Keep
- (L) Reason

#### **4.3.5.11 Missing Nursing and or Allied Health Costs**

This is the same as Mental Health audit report (refer to section 4.3.3.11)

#### **4.3.5.12 Service Dates**

This is the same as Mental Health audit report (refer to section 4.3.3.12)

### **4.3.6 COMMUNITY CARE ACCESS CENTRE CLIENT**

*Coming Soon*

## **4.4 RECONCILIATION AND FINAL SUMMARY RESULTS**

After final review of the audit results, records and/or cases are excluded from the audit response files agreed to by both the MOHLTC and the hospital. The MOHLTC cleanses the data and reconciles the OCCI data to the OCDM (Ontario Cost Distribution Methodology) data. A comparison is made of the hospital's OCDM total cost with the OCCI final total cost. Table 4.14 is a sample of the template used to reconcile OCCI costing and OCDM results.

The criteria for passing the reconciliation process are shown in Table 4.13.

**Table 4.13: Passing criteria**

<b>Pre-existing Hospitals</b>	<b>Milestone Hospitals</b>
% Records Deleted < 5% (Acute)	% Records Deleted < 20% (Acute)
% Records Deleted < 20% (AM, MH, CC & RH)	% Records Deleted < 20% (AM, MH, CC & RH)
OCCI Total Cost vs. OCDM > 95% (Acute)	OCCI Total Cost vs. OCDM > 80%
OCCI Total Cost vs. OCDM > 95% (Acute)	

Note: AM = Ambulatory  
 MH = Mental Health  
 CC = Chronic Care  
 RH = Rehab

**Table 4.14: Template Sample**

Summary for Sunshine Hospital AIP 0809				Records Deleted		Cases Deleted	
				Group	Count	Group	Count
Records Total (Submitted)			400,000	Not matched with CIHI data	500	Not matched with CIHI data	10
Records Total (Qualified)			399,400	Zero Total Cost	100	Zero Total Cost	0
Records Deleted			0	<i>(Unmatched CIHI records/cases /costs are not included in total submitted)</i>			
% Records Deleted			0.00%	Duplicated FC	0	Duplicated FC	0
Cases Total (Submitted)			18,000	No Nursing Cost	0	No Nursing Cost	0
Cases Total (Qualified)			17,990	Only One FC	0	Only One FC	0
Cases Deleted			0	Missing OR Cost	0	Missing OR Cost	0
% Cases Deleted			0.00%	Total Cost <\$100 or >=\$1M	0	Total Cost <\$100 or >=\$1M	0
	Direct Cost	Indirect Cost	Total Cost	Below Minimum Cost	0	Below Minimum Cost	0
Total cost submitted	\$80,000,000	\$20,000,000	\$100,000,000	Invalid Service Date	0	Invalid Service Date	0
Total final cost	\$80,000,000	\$20,000,000	\$100,000,000	Zero DC and/or Zero IDC	0	Zero DC and/or Zero IDC	0
Total cost deleted	\$0	\$0	\$0	Missing Nursing Cost	0	Missing Nursing Cost	0
% cost deleted	0.00%	0.00%	0.00%	<b>Total Records Deleted</b>	<b>0</b>	<b>Total Cases Deleted</b>	<b>0</b>
OCCI Submitted Direct/Indirect ratio	80.00%	20.00%	100.00%				
OCCI Final Direct/Indirect ratio	78.50%	21.50%	100.00%				
OCDM FY 08/09	\$80,000,000	\$20,000,000	\$100,000,000				
OCDM FY 08/09 Direct/Indirect ratio	80.00%	20.00%	100.00%				
OCCI Total Cost vs. OCDM	80.00%	20.00%	100.00%				

Records Total (Submitted) = Total number of records in the OCCI submission file

Records Total (Qualified) = Total number of OCCI records being audited (Records Total (submitted) – Not Matched with CIHI Data – Zero Total Cost)