

OCCI SUBMISSION TECHNICAL SPECIFICATIONS

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5.1 THE OCCI SUBMISSION PROCESS

The annual submission consists of patient descriptive and financial data. The submission is sent in separate files by patient population type and is reported by day of stay at the patient encounter level.

The annual submissions are audited and a report containing records that did not meet the case costing standards is sent to hospitals. Hospitals must review the report, correct the record errors and re-submit the data. OCCI staff at the ministry are available to answer any questions and assist during the submission process. Records that cannot be corrected should be deleted from the submission.

Submission for Hospitals using Ministry hosted Provincial Software Solution

The submission process is managed within the Medassets Software system. Hospitals are required to run a series of audit reports in order to generate the submission file. Hospitals must review the audit reports and correct the applicable data errors. The submission file is sent using the file transfer program in Medassets. E-mail notification is required to the ministry that the submission file has been sent.

For a complete listing of all OCCI audit reports, see the document OCCI Audit Reports Review, Version 7.0. Data Compliance Review Tool, Version FY 2008/2009.

5.2 OCCI SUBMISSION REQUIRMENTS

A standard file layout has been defined for all patient populations (Acute Inpatient, Ambulatory, Mental Health, Rehabilitation, Complex Continuing Care and Community Care Access Centre). See section 5.6 OCCI Case Cost Record See Appendix D for details.

Additional submission requirements should also be included. The requirements are:

Calculation of Patient-Specific Cost Distribution Percentage Report - see Appendix E section 5.7 Additional Submission Requirements for further details.

Cost Distribution Bases Table

Transient Cost Centres (TCC) Transient Functional Centres (TFC) Cost Allocation Methodology Table - see Appendix F section 5.7.3 TFC Cost Allocation Methodology Table for requirements and details.

5.3 EDITS AND ERRORS

The submission is reviewed for data compliance. The data is submitted by hospitals and is subject to edits. These edits help to ensure that the data formats are valid and that the individual values are within the allowable ranges. The first edit checks are for valid data formats and data completeness.

The edits are classified into three levels of severity: Level 1, Level 2 and Level 3:

Level 1 Edits and Errors

Record length does not match expected length for this file (see allowable record lengths Appendix D section 5.6 OCCI Case Cost Record)

The chart number, registration number, admission date and/or functional centre code is missing.

Level 1 errors are severe and result in the rejection of the complete file, which must be corrected and resubmitted in its entirety.

Level 2 Edits and Errors

Alphabetic character (other than “.”) in numeric fields. The error listing identifies the field name(s).

Invalid alphabetic characters in alphabetic fields (allowable values are blanks, A-Z (upper and lower case), 0-9,!@#%&*()_+-.:;<>?,./). The error listing identifies the field name(s).

Level 3 “Matching Criteria”

In order to link the financial and patient descriptive data, it is essential that the key elements submitted to CIHI by the hospitals match the key elements in the hospital’s case costing submission. There must be an exact match otherwise cases with their respective cost are excluded from the OCCI Submission and subsequent audit process. It is recommended that facilities review the format of the key data elements used for linkages are in place for both the costing and clinical information.

For each patient population, there are key elements that link the CIHI patient descriptive data to the case costing data. The key elements for each patient population are listed in Table 5.1.

Table 5.1: Key Elements by Patient Population

Acute Inpatient	Complex Continuing Care	Ambulatory Care/ NACRS	Mental Health	Rehabilitation
Master number 5 characters	Master number 5 characters	Master number 5 characters	Master number 5 characters	Master number 5 characters
Patient chart number 10 characters	Patient chart number 10 characters	Patient chart number 10 characters	Patient chart number 12 characters	Patient chart number 12 characters
Registration/account number 7 characters	Resident code (URI) 20 characters	Registration/account number 12 characters	Case Record number (registration number) 12 characters	N/A
Admission date	Date of entry	Date of visit	Admission date	Admission date

Acute Inpatient	Complex Continuing Care	Ambulatory Care/ NACRS	Mental Health	Rehabilitation
YYYYMMDD 8 characters	YYYYMMDD 8 characters	YYYYMMDD 8 characters	YYYYMMDD 8 characters	YYYYMMDD 8 characters
		MIS-OHRS Functional Centre		

Note: CCAC clinical data is not available – only submission of costing records required.

The master number is different for each patient population and hospital (i.e. acute inpatient data is submitted using a different master number than ambulatory care data). The MOHLTC has assigned institution identifiers based on the Master Numbering System. **Please ensure that the master number used corresponds to the master number for the current fiscal year’s data submission.**

The Chart Number is the patient’s historical medical record number within each institution.

The Registration/Account /Resident code/Case Record number is the unique visit identifier within a given year.

While not required, it is recommended that hospitals submit the Case Mix Group assignment. See Table 5.2 to determine the relevant Case Mix Grouping methodology for each patient population.

Table 5.2: Patient Population by Patient Classification Systems

Patient Population	Patient Classification System
Acute Inpatient	Case Mix Group (CMG Plus)
Ambulatory Care (includes Day Surgery)	Comprehensive Ambulatory Classification System (CACS)
Mental Health	System for Classification of Inpatient Psychiatry (SCIPP)
Complex Continuing Care	Resource Utilization Group (RUG-III)
Rehabilitation	Rehabilitation Patient Group (RPG)

If a relatively large number of level 2 **or level 3** errors are detected, the file is also rejected, and the hospital must correct the data and resubmit the file in its entirety.

If only a few level 2 **or level 3** errors are detected, the file is processed, and a listing of the errors is included in the audit report.

This completes the initial processing of each hospital’s case costing data. It is expected that processing is completed within two weeks from the time the submission is received by the **OCCI team at the MOHLTC.**

5.4 PATIENT DESCRIPTIVE DATA

Hospitals should follow CIHI's rules and standards for coding the OCCI mandatory data. For details of these rules, please refer to the appropriate CIHI manual. Required data fields have been established for each patient type and include CIHI optional elements. The following optional elements are required for OCCI as outlined in [Table 5.3](#).

Table 5.3: CIHI Optional Elements

Acute Inpatient Discharge Abstract Database (DAD)	Ambulatory Care National Ambulatory Care Reporting System (NACRS)	Rehabilitation National Rehabilitation Reporting System (NRS)	Mental Health Ontario Mental Health Reporting System (OMHRS)
Intervention location code OR # (1-20)	Intervention code (1-10)	Total Service Interruption Days for Rehabilitation patients	Total days away from bed (X130)
Service transfer code (1-3)	Location code of intervention (1-10)		
Service transfer days (1-3)			

5.5 FINANCIAL COSTING DATA

As a minimum requirement, hospitals must submit costs by:

- day of stay or service date,
- functional centre, according to the Ontario Healthcare Reporting Standards (OHRS) Version 7.0 Level 4 functional centre (Level 3 for small facilities),
- cost type as seen in Table 5.4 below, and
- costs allocated by OCCI approved distribution bases.

Table 5.4: Required Cost Types

Cost Type	OHRS Secondary Accounts	Distribution Bases
Variable Direct Labour	Compensation (including benefits): 3 50 ** Unit Producing 3 90 90 Medical Fee for Service	workload, or patient hours
Variable Direct Supplies-Service Recipient Specific	5 ** ** Service Recipient Specific	patient specific
Variable Direct Supplies – General	4 ** ** Supplies	workload, or patient hours, or patient day, or exam, or case
Variable Direct Other	8 ** ** Contracted Out	workload, or patient hours, or exam

Cost Type	OHRS Secondary Accounts	Distribution Bases
Fixed Direct Labour	Compensation (including benefits): 3 10 ** Management and Operational Support 3 90 10 to 3 90 85 Medical (Salaried Physicians)	workload, or patient hours, or patient day, or exam, or case
Fixed Direct Other	6 ** ** Sundry	workload, or patient hours, or patient day, or exam, or case
Fixed Direct Building, Equipment and Grounds	7 ** ** Equipment Expense (including Amortization) 9 ** ** Buildings and Grounds Expense	workload, or patient hours, or patient day, or exam, or case
Indirect (It is mandatory to report indirect cost types as fixed costs. It is optional to further categorize indirect costs as variable or fixed)		

Hospitals and **Community Care Access Centres** are required to submit costs for patient populations as follows **listed in Table 5.5:**

Table 5.5: Criteria for Submitting Costs by Patient Population

Patient Population	Criteria for OCCI Submission
Acute Inpatient	All patients discharged within the costing period
Ambulatory Care (includes Day Surgery)	All patients whose service dates are within the costing period
Mental Health	All patients whose service dates are within the costing period
Complex Continuing Care	All patients whose service dates are within the costing period
Rehabilitation	All patients whose service dates are within the costing period
Community Care Access Centre	All clients/referrals whose service dates are within the costing period.

Mismatching and/or missing cases are reported as part of the data quality review.

5.6 OCCI CASE COST RECORD

Table 5.6 has the OCCI case cost record for **Acute Inpatient, Ambulatory, Rehabilitation and Mental Health** patient populations. **Table 5.7 has the case cost record for Complex Continuing Care and Table 5.8 the file layout for submissions for Community Care Access Centres will be coming soon.**

Note:

- All fields must be right justified
- Chart number and Register/Account number must be in the same format as in the files that are submitted to CIHI.
- File starts at the 1st byte with specific length for each data field
- Type indicates the type of a variable where N= Numeric and A= Alphanumeric

Table 5.6: OCCI Costing Data Elements in the Case Cost Record for Acute Inpatient, Ambulatory, Rehabilitation and Mental Health

Start Byte	Length	Attribute Name	Type	Valid Values	Description or Comments
1	4	Institution ID	A	0000-9999	Master number as indicated in the Master Numbering Book and as submitted to CIHI. Must match the specific patient service type being reported to CIHI.
5	12	Chart Number	A	per CIHI	The Chart number refers to the patient file number assigned by the reporting facility.
17	12	Register/Account Number	A	per CIHI	The Register/Account is the number assigned sequentially at the beginning of each fiscal year for every patient that is admitted/registered to a health care facility. Case Record number for OMHRS
29	3	-- Reserved/Blank	A		Unused area, leave blank
32	8	Admission Date or Date of Registration	A	YYYYMMDD	The Admission Date is the calendar date that the patient was officially registered as an inpatient, ambulatory, Mental Health or Rehab patient in the facility
40	8	Discharge Date	A	YYYYMMDD	The Discharge Date is the calendar date that the patient was formally discharged from the nursing unit of the reporting facility Equivalent to disposition date in NACRS.
48	5	Functional Centre Code OHRs Level 3	A		OHRs functional centre codes V 7.0
53	2	OHRs Level 4	A	00-99	Put zeroes instead of blanks
55	2	OHRs Level 5	A	00-99	Put zeroes instead of blanks
57	8	Date of Service	A	YYYYMMDD	The date the service or procedure was performed. The day the services are received by a patient
65	9	Variable Direct Labour \$	N	000000.00 - 999999.00	Leading zeroes are permitted

Start Byte	Length	Attribute Name	Type	Valid Values	Description or Comments
74	9	Variable Direct Supplies \$ – Patient Specific	N	000000.00 - 999999.00	Leading zeroes are permitted
83	9	Variable Direct Supplies \$ – General	N	000000.00 - 999999.00	Leading zeroes are permitted
92	9	Variable Direct Other \$	N	000000.00 - 999999.00	Leading zeroes are permitted
101	9	Fixed Direct Labour \$	N	000000.00 - 999999.00	Leading zeroes are permitted
110	9	Fixed Direct Other \$	N	000000.00 - 999999.00	Leading zeroes are permitted
119	9	Fixed Direct Equipment \$	N	000000.00 - 999999.00	Leading zeroes are permitted
128	9	Indirect Variable Cost \$	N	000000.00 - 999999.00	Leading zeroes are permitted
137	9	Indirect Fixed Cost \$	N	000000.00 - 999999.00	Leading zeroes are permitted
146	4	Hospital Grouper	A	valid grouper code	Patient classification assignment by facility (OPTIONAL)
150	10	Principle Procedure Intervention	A	CCI Procedure code	CCI Procedure codes (OPTIONAL)
160	2	Principal Intervention Location	N	01-11	Required to audit missing Operating Room costs (OPTIONAL)
162	8	Assessment Reference Date	N	N	Must match patient description record submitted to CIHI (OPTIONAL)
170	4	Total Days Away From Bed	N	0000-9999	Element ID X130 from OMHRS submission file or Total Service Interruption Days for Rehabilitation patients (OPTIONAL)

Table 5.7: OCCI Costing Data Elements in the Case Cost Record for Complex Continuing Care

Start Byte	Length	Attribute Name	Type	Valid Values	Description or Comments
1	4	Institution ID	A	0000-9999	Master number as indicated in the Master Numbering Book and as submitted to CIHI. Must match the specific patient service type being reported to CIHI.
5	12	Health Record Number	A	per CIHI	
17	20	Unique Registration Identifier (URI)	A	per CIHI	The URI identifies the resident admission.
37	3	-- Reserved/Blank	A		Unused area, leave blank

Start Byte	Length	Attribute Name	Type	Valid Values	Description or Comments
39	8	Admission Date or Date of Registration	A	YYYYMMDD	The Admission Date is the calendar date that the patient was officially registered as a Chronic Care patient
48	8	Discharge Date	A	YYYYMMDD	The Discharge Date is the calendar date that the patient was formally discharged from the Chronic Care Unit/facility
56	5	Functional Centre Code OHRs Level 3	A		OHRs functional centre codes V 7.0
61	2	OHRs Level 4	A	00-99	Put zeroes instead of blanks
63	2	OHRs Level 5	A	00-99	Put zeroes instead of blanks
65	8	Date of Service	A	YYYYMMDD	The date the service or procedure was performed. The day the services are received by a patient
73	9	Variable Direct Labour \$	N	000000.00 - 999999.00	Leading zeroes are permitted
82	9	Variable Direct Supplies \$ – Patient Specific	N	000000.00 - 999999.00	Leading zeroes are permitted
91	9	Variable Direct Supplies \$ – General	N	000000.00 - 999999.00	Leading zeroes are permitted
100	9	Variable Direct Other \$	N	000000.00 - 999999.00	Leading zeroes are permitted
109	9	Fixed Direct Labour \$	N	000000.00 - 999999.00	Leading zeroes are permitted
118	9	Fixed Direct Other \$	N	000000.00 - 999999.00	Leading zeroes are permitted
127	9	Fixed Direct Equipment \$	N	000000.00 - 999999.00	Leading zeroes are permitted
136	9	Indirect Variable Cost \$	N	000000.00 - 999999.00	Leading zeroes are permitted
145	9	Indirect Fixed Cost \$	N	000000.00 - 999999.00	Leading zeroes are permitted
154	4	Hospital Grouper	A	valid grouper code	Patient classification assignment by facility (OPTIONAL)
158	8	Assessment Reference Date	N	N	Must match patient description record submitted to CIHI (OPTIONAL)

Table 5.8: OCCI Costing Data Elements in the Case Cost Record for Community Care Access Centre –coming soon

5.7 ADDITIONAL SUBMISSION REQUIREMENTS

The percentage of distributed operational costs to patients must follow OCCI standards. To determine if a hospital meets the OCCI standards for minimum percentage of operational cost distributed to patients, the **templates in Appendix E, Patient Specific Cost Distribution**, must be completed.

If the hospital's calculated percentage (based on the mandatory and planned functional centre costs to be distributed) is below the minimum, the hospital is required to distribute the costs of additional functional centres until the minimum requirement is met. **If the minimum standards described are not met, the submission is not accepted.**

The OCCI Standards by patient type are as follows:

Acute Inpatient

For the first year of case costing, a minimum of 80% of acute inpatient operating costs must be distributed to patients in the functional centres listed in Table 5.9.

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

Table 5.9: Mandatory Functional Centres to be Distributed for Acute Inpatient

7*2**** to 7*27****	Nursing Inpatient Services (IP)
7*410**	LAB Clinical Laboratory
7*415**	DI Diagnostic Imaging
7*440**	PH Pharmacy

Ambulatory Care

A minimum of 80% of ambulatory care operating costs must be distributed to patients in the functional centers shown in Table 5.10.

Table 5.10: Mandatory Functional Centres to be Distributed/Costed for Ambulatory Care

7*310**	AC Emergency (ER)
7*340**	AC Specialty Day/Night Care Day Surgery
7*3501070	AC Clinic Medical - Pre Admission Clinic
7*3501545	AC Clinic Surgical - Pre Admission Clinic
7*410**	LAB Clinical Laboratory
7*415**	DI Diagnostic Imaging
7*430**	NV Non-Invasive Cardiology and Vascular Laboratories
7*440**	PH Pharmacy
7*450	TH Physiotherapy
7*455**	TH Occupational Therapy
7*470**	TH Social Work

Mental Health

A minimum of 80% of mental health operating costs must be distributed to patients from the functional centres given in Table 5.11.

Table 5.11: Mandatory Functional Centres to be Distributed for Mental Health

7*276**	IP Mental Health
7*410**	LAB Clinical Laboratory
7*415**	DI Diagnostic Imaging
7*430**	NV Non-Invasive Cardiology and Vascular Laboratories
7*440**	PH Pharmacy
7*470**	TH Social Work

Rehabilitation

A minimum of 80% of rehabilitation operating costs must be distributed to patients to the functional centres listed in Table 5.12.

Table 5.12: Mandatory Functional Centres to be Distributed for Rehabilitation

7*281**	IP Rehabilitation IP
7*450	TH Physiotherapy
7*455**	TH Occupational Therapy
7*470**	TH Social Work

Complex Continuing Care

A minimum of 80% of complex continuing care operating costs must be distributed to patients.

Table 5.13: Mandatory Functional Centres to be Distributed for Complex Continuing Care

7*295**	IP Long Term Care IP
7*450	TH Physiotherapy
7*455**	TH Occupational Therapy
7*470**	TH Social Work

5.7.1 Patient Specific Cost Distribution Percentage Report

Appendix E has the MS Excel file that must be submitted to confirm the percentage of costs to be distributed to patients for each patient population. Included in the excel file are instructions for completing the calculations and are given below in the README tab.