TITLE 7 HEALTH
CHAPTER 1 HEALTH GENERAL PROVISIONS
PART 4 DATA REPORTING REQUIREMENTS FOR HEALTH CARE FACILITIES

7.1.4.1 ISSUING AGENCY: New Mexico Health Policy Commission.
[7.1.4.1 NMAC - Rp, 7.1.4.1 NMAC, 11/14/2008]

7.1.4.2 SCOPE: This rule applies to all licensed inpatient and outpatient general and specialty health care facilities located within New Mexico.
[7.1.4.2 NMAC - 7.1.4.2 NMAC, 11/14/2008]

7.1.4.3 STATUTORY AUTHORITY: This rule is promulgated pursuant to Sections 24-14A-3D(5) and (6); 24-14A-5A through C; 24-14A-8A and B; and 24-14A-9 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.
[7.1.4.3 NMAC - Rp, 7.1.4.3 NMAC, 11/14/2008]

7.1.4.4 DURATION: Permanent.
[7.1.4.4 NMAC - Rp, 7.1.4.4 NMAC, 11/14/2008]

7.1.4.5 EFFECTIVE DATE: November 14, 2008, unless a later date is cited at the end of a section.
[7.1.4.5 NMAC - Rp, 7.1.4.5 NMAC, 11/14/2008]

7.1.4.6 OBJECTIVE: The purpose of this rule is to specify the data reporting requirements for licensed inpatient and outpatient general and specialty health care facilities pursuant to the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.
[7.1.4.6 NMAC - Rp, 7.1.4.6 NMAC, 11/14/2008]

7.1.4.7 DEFINITIONS: In addition to the definitions in the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, the following terms have the following meaning for purposes of this rule.

A. **Admission hour** coded in military time (e.g., 2:45 p.m. is represented as 1445).

B. **Attending physician NPI** the national provider identifier (NPI), a unique, government-issued, standard identification 10-digit number for individual health care providers and provider organizations like clinics, hospitals, schools and group practices.

C. **Birth weight** coded in grams.

D. **Data provider** means a data source that has provided data to the health information system on a regular basis.

E. **Data source** has the meaning given in Section 24-14A-2 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and includes those categories of persons or entities that possess health information, including any public or private sector licensed hospital, health care practitioner, primary care clinic, ambulatory surgery center, ambulatory urgent care center, ambulatory dialysis unit, home health agency, long-term care facility, pharmacy, third-party payer and any public entity that has health information

F. **Discharge hour** coded in military time (e.g., 2:45 p.m. is represented as 1445).

G. **1st E-code** means the first code for external causes of injury, poisoning, or adverse effect. If a patient has an injury diagnosis in a range of ICD-9-CM 800-999, e-codes are required.

H. **2nd E-code** means the second code for external causes of injury, poisoning, or adverse effect. If a patient has an injury diagnosis in a range of ICD-9-CM 800-999, e-codes are required.

I. **3rd E-code** means the third code for external causes of injury, poisoning, or adverse effect. If a patient has an injury diagnosis in a range of ICD-9-CM 800-999, e-codes are required.

J. **Health care** means any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition.

K. **Health information system or HIS** means the health information system established by the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

L. **Inpatient health care facility** means a hospital or other health facility which admits patients for overnight or longer (and therefore is responsible for patients' room and board) for the purpose of providing diagnostic treatment or other health services.

M. **Medicare provider number** means the six digit number assigned by Medicare to the data source providing the reported service(s).

N. **National provider identifier (NPI)** means the ten digit NPI from the national plan and provider enumeration system (NPPES).

O. **New Mexico state license number** means the four to eight digit license number issued by the New Mexico health department for the data source providing the reported service(s).

P. **Operating physician NPI** the national provider identifier (NPI), a unique, government-issued, standard identification 10-digit number for individual health care providers and provider organizations like clinics, hospitals, schools and group practices.

Q. **Outpatient health care facility** means a hospital or other health facility that provides ambulatory care to a patient without admitting the patient to the facility or providing lodging services.

R. **Patient** means a person who has received or is receiving health care.

S. **Patient admission date** means the date the patient was admitted by the provider for inpatient care. Format as "MMDDYYYY". For example, if the admission date was July 1, 1983, "07011983" would be coded.

T. **Patient street address** means the mailing address of the patient at the time of discharge including street name and number or post office box number or rural route number.

U. **Patient city** means the city of the patient's residence at the time of discharge.

V. **Patient county** means the county of the patient's residence at the time of discharge.

W. **Patient state** means the state of the patient's residence at the time of discharge.

X. **Patient zip code** means the zip code of the patient's residence at the time of discharge. Use either five or nine digits, e.g. 87501 or 875010968.

Y. **Patient control number** means the patient's unique alpha-numeric number assigned by the provider.

Z. **Patient date of birth** means the date of birth of the patient. Required format is "MMDDYYYY". Note that all four digits of year are required, e.g., "08191898" is for August 19, 1898.

AA. **Patient discharge date** means the date the patient was discharged by the provider from the inpatient health care facility. Formatted as "MMDDYYYY".

BB. **Patient diagnosis related group (DRG) code** means the diagnostic related group code.

CC. **Patient EMS ambulance run number** means the emergency medical services ambulance run number.

DD. **Patient race** means the classification(s) of a patient's stated race to include one or multiple reported classifications, coded as shown below. When reporting multiple classifications do not use spaces or delimiters. For example, if a patient states that he or she is both Asian and other the race field would be R1R5.

(1) R1 - American Indian.
(2) R2 - Asian (including Asian Indian, Chinese, Filipino, Japanese, Korean and Vietnamese).
(3) R3 - Black or African American.
(4) R4 - Native Hawaiian or Pacific Islander (including Chamorro and Samoan).
(5) R5 - White.
(6) R6 - patient refused.
(7) R7 - unknown.
(8) R9 - other race.

EE. **Patient ethnicity** means the gross classification of a patient's stated ethnicity, coded as follows:

(1) Y - Hispanic or Latino;
(2) N - not Hispanic or Latino.

FF. **Patient tribal affiliation** means the classification(s) of patient's stated New Mexico tribal affiliation. Up to five reported affiliations can be reported, coded as shown below. When reporting multiple affiliations do not use spaces or delimiters. For example, if a patient states that he or she has affiliations with both Acoma pueblo and the Navajo nation the tribal affiliation field would be T1T22:

(1) T1 - Acoma pueblo;
(2) T2 - Cochiti pueblo;
(3) T3 - Isleta pueblo;
(4) T4 - Jemez pueblo;
(5) T5 - Jicarilla Apache nation;
(6) T6 - Kewa/Santo Domingo pueblo;
(7) T7 - Laguna pueblo;
(8) T8 - Mescalero Apache nation;

(9) T9 - Nambe pueblo;
(10) T10 - Ohkay Owingeh pueblo;
(11) T11 - Picuris pueblo;
(12) T12 - Pojoaque pueblo;
(13) T13 - San Felipe pueblo;
(14) T14 - San Ildefonso pueblo;
(15) T15 - Sandia pueblo;
(16) T16 - Santa Ana pueblo;
(17) T17 - Santa Clara pueblo;
(18) T18 - Taos pueblo;
(19) T19 - Tesuque pueblo;
(20) T20 - Zia pueblo;
(21) T21 - Zuni pueblo;
(22) T22 - New Mexico Navajo nation;
(23) T100 - other tribal affiliation;
(24) T200 - patient refused;
(25) T300 - unknown.

GG. **Patient first name** means the first name of the patient.

HH. **Patient last name** means the last name of patient. Last name should not have a space between a prefix and a name (as in MacBeth), but hyphenated names retain the hyphen (as in Smith-Jones). Titles should not be recorded. If the last name has a suffix, put the last name, a space, and then the suffix (as in "Snyder III"). Last name does not include abbreviations of academic achievement or profession, such as "M.D.", "Ph.D." etc.

II. **Patient middle initial** means the middle initial of the patient.

JJ. **Patient medicaid number** means the patient's unique identification number assigned by medicaid.

KK. **Patient medical record number** means the medical record number used by the provider to identify the patient.

LL. **Patient principle diagnosis code, patient 2nd diagnosis code, patient 3rd diagnosis code, patient 4th diagnosis code, patient 5th diagnosis code, patient 6th diagnosis code, patient 7th diagnosis code, patient 8th diagnosis code, patient 9th diagnosis code, patient 10th diagnosis code, patient 11th diagnosis code, patient 12th diagnosis code, patient 13th diagnosis code patient 14th diagnosis code, patient 15th diagnosis code, patient 16th diagnosis code, patient 17th diagnosis code, patient 18th diagnosis code** means the ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.

MM. **Patient principle diagnosis code, present on admission; patient 2nd diagnosis code; present on admission; patient 3rd diagnosis code, present on admission; patient 4th diagnosis code, present on admission; patient 5th diagnosis code, present on admission; patient 6th diagnosis code, present on admission; patient 7th diagnosis code, present on admission; patient 8th diagnosis code, present on admission; patient 9th diagnosis code, present on admission; patient 10th diagnosis code, present on admission; patient 11th diagnosis code, present on admission; patient 12th diagnosis code, present on admission; patient 13th diagnosis code, present on admission; patient 14th diagnosis code, present on admission; patient 15th diagnosis code, present on admission; patient 16th diagnosis code, present on admission; patient 17th diagnosis code, present on admission; patient 18th diagnosis code, present on admission** means diagnosis was present at the time the order for inpatient admission occurs - conditions that develop during an outpatient encounter, including emergency room, observation, or outpatient surgery are considered as present on admission.

(1) Y - yes
(2) N - no
(3) U - no information on the record
(4) W - clinically undetermined
(5) 1 - exempt

NN. **Patient principal procedure code, patient 2nd procedure code, patient 3rd procedure code, patient 4th procedure code, patient 5th procedure code, patient 6th procedure code** means the codes identifying the significant procedures, performed during the patient stay.

OO. **Procedure date for patient principal procedure code, procedure date for 2nd procedure code, procedure date for 3rd procedure code, procedure date for 4th procedure code, procedure date for 5th**

procedure code, procedure date for 6th procedure code, means the date of the procedure that is reported as it coincides with the procedure code that was performed (mmddyyyy).

PP. **Patient social security number** means the nine digit social security number provided by the patient, without section separating characters like dashes, hyphens or slashes, for example, "585940323".

QQ. **Patient status** means the code indicating patient disposition at time of discharge. The codes are:

(1) 01 - discharged to home or self care (routine discharge);

(2) 02 - discharged/transferred to another general hospital;

(3) 03 - discharged/transferred to skilled nursing facility;

(4) 04 - discharged/transferred to intermediate care facility (ICF);

(5) 05 - discharged/transferred to another type of institution;

(6) 06 - discharged/transferred to home under care of organized home health service organization;

(7) 07 - left against medical advice;

(8) 08 - reserved for national assignment;

(9) 09 - admitted as an inpatient to this hospital;

(10) 10 - 19 reserved for national assignment;

(11) 20 - expired;

(12) 21 - discharged/transferred to court/law enforcement (covers patients sent to jail, prison or other detention facilities);

(13) 22 - 29 - reserved for national assignment;

(14) 30 - still patient or expected to return for outpatient services;

(15) 31 - 39 - reserved for national assignment;

(16) 40 - expired at home (hospice claims only);

(17) 41 - expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (hospice claims only);

(18) 42 - expired - place unknown (hospice claims only);

(19) 43 - discharged/transferred to a federal health care facility; (effective 03/31/2008) (usage note: discharges and transfers to a government operated health care facility such as a department of defense hospital, a veteran's administration (VA) hospital or VA hospital or a VA nursing facility; to be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not);

(20) 44 - 49 - reserved for national assignment;

(21) 50 - discharged/transferred to hospice - home;

(22) 51 - discharged/transferred to hospice - medical facility;

(23) 52 - 60 - reserved for national assignment;

(24) 61 - discharged/transferred within this institution to a hospital based medicare approved swing bed;

(25) 62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital;

(26) 63 - discharged/transferred to long term care hospitals;

(27) 64 - discharged/transferred to a nursing facility certified under medicaid but not certified under medicare;

(28) 65 - discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital;

(29) 66 - discharged/transferred to a critical access hospital (CAH) (effective 03/31/2008);

(30) 67 - 69 reserved for national assignment;

(31) 70 - discharge/transfer to another type of health care institution not defined elsewhere in the code list (effective 03/31/2008);

(32) 71-99 - reserved for national assignment.

RR. **Primary payer category** means one of the following broad categories assigned by the data provider to the payment source identified in the primary payer identification name field.

(1) 1 **Medicare** is the primary payer from which the provider might expect some payment.

(2) 2 **Medicaid** is the primary payer from which the provider might expect some payment.

(3) 3 **CHAMPUS/military/VA** is the primary payer from which the provider might expect some payment.

(4) 4 **IHS/PHS** (Indian health service/public health service) is the primary payer from which the provider might expect some payment.

(5) 5 **Other government** (including corrections/research) is a government entity other than those specifically listed as the primary payer from which the provider might expect some payment.

(6) 6 **Private insurance** is the primary payer from which the provider might expect some payment.

(7) 7 **Workers compensation** is the primary payer from which the provider might expect some payment.

(8) 8 **Self pay/no insurance** means the patient (or the patient's family) is the primary payer from which the provider might expect some payment.

(9) 9 **County indigent funds** are the primary payer source from which the provider might expect some payment.

(10) 10 **Charity care** means the provider does not anticipate any payment from any source, including the patient.

(11) 88 **Unknown**.

SS. **Primary payer identification name** means the name identifying the primary payer from which the provider might expect some payment for the reported service(s).

TT. **Primary payer type** means the type of primary payer as defined below from which the provider might expect some payment for the reported services(s):

(1) 1 **HMO** - health maintenance organization;

(2) 2 **other managed care** - includes provider service networks;

(3) 3 **indemnity plan;**

(4) 88 **unknown.**

UU. **Provider zip code** means the zip code whose boundaries physically contain the facility where the reported service(s) were provided. Use either five or nine digits, e.g. 87501 or 875010968.

VV. **Secondary payer category** means one of the following broad categories assigned by the data provider to the payment source identified in the secondary payer identification name field.

(1) 1 - **Medicare** is the secondary payer from which the provider might expect some payment.

(2) 2 - **Medicaid** is the secondary payer from which the provider might expect some payment.

(3) 3 - **CHAMPUS/military/VA** is the secondary payer from which the provider might expect some payment.

(4) 4 - **IHS/PHS** (Indian health service/public health service) is the secondary payer from which the provider might expect some payment.

(5) 5 - **Other government** (including corrections/research) is a government entity other than those specifically listed as the secondary payer from which the provider might expect some payment.

(6) 6 - **Private insurance** is the secondary payer from which the provider might expect some payment.

(7) 7 - **Workers compensation** is the secondary payer from which the provider might expect some.

(8) 8 - **Self pay/no insurance** means the patient (or the patient's family) is the secondary payer from which the provider might expect some payment.

(9) 9 - **County indigent funds** are the secondary payer source from which the provider might expect some payment.

(10) 10 - **Charity care** means the provider does not anticipate any payment from any source, including the patient.

(11) 88 - **Unknown**.

WW. **Secondary payer identification name** means the name identifying a secondary payer from which the provider might expect some payment for the reported service(s).

XX. **Secondary payer type** means the type of secondary payer as defined below from which the provider might expect some payment for the reported service(s):

(1) 1 - **HMO** - health maintenance organization;

(2) 2 - **other managed care** - includes provider service networks;

(3) 3 - **indemnity plan;**

(4) 88 - **unknown**.

YY. **Sex of patient** means the sex of the patient as recorded at discharge. Enter the sex of the patient, coded as follows:

(1) female - F;

(2) male - M;

(3) unknown - U.

ZZ. **Point of origin for admission or visit** means the source of referral for this admission.

(1) **Adults and pediatrics:** source of admission codes for adults and pediatrics are:

(a) 1 - non-health care facility point of origin - the patient was admitted to this facility upon the recommendation of his or her personal physician if other than a clinic physician or a HMO physician (this includes patients coming from home, a physician's office or workplace;

(b) 2 - clinic referral - the patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic;

(c) 4 - transfer from a hospital - the patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient or outpatient (excludes transfers from hospital inpatient in the same facility);

(d) 5 - transfer from SNF or ICF - the patient was admitted to this facility as a transfer from a skilled nursing facility (SNF) or intermediate care facility (ICF) where he or she was a resident;

(e) 6 - transfer from another health care facility - the patient was admitted to this facility as a transfer from a health care facility not defined elsewhere in this code list (i.e. other than an acute care facility or skilled nursing facility);

(f) 8 - court/law enforcement - the patient was admitted to this facility upon the direction of a court of law, or upon a request of a law enforcement agency representative (includes transfers from incarceration facilities);

(g) 9 - information not available - the means by which the patient was referred to this facility is not known;

(h) A - reserved for national assignment;

(i) D - transfer from hospital inpatient in the same facility resulting in a separate claim to the payer - the patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer;

(j) E - transfer from ambulatory surgery center - the patient was admitted to this facility from an ambulatory or same-day surgery center (does not include patients admitted from the same facilities' outpatient surgery department);

(k) F - transfer from hospice and is under a hospice plan of care or enrolled in a hospice program - the patient was admitted to this facility as acute inpatient status and was receiving hospice care;

(l) G-Z - reserved for national assignment.

(2) **Newborns:** Newborn codes must be used when the **type of admission** is code 4. The codes are:

(a) 5 - born inside this facility - a baby born inside this facility;

(b) 6 - born outside of this facility - a baby born outside of this facility;

AAA. **Total charges** means an 11 digit number rounded to the whole dollar for the total charges for all inpatient services reported.

BBB. **Traffic crash report number** means the six digit number of the traffic crash/accident report form.

CCC. **Type of admission** means an Inpatient code indicating the priority of the admission. Type of admission codes are:

(1) 1--emergency - the patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions; generally, the patient is admitted through the emergency room;

(2) 2--urgent - the patient requires immediate medical attention for the care and treatment of a physical or mental disorder; generally, the patient is admitted to the first available and suitable accommodation;

(3) 3--elective - the patient's condition permits adequate time to schedule the availability of a suitable accommodation;

(4) 4--newborn - a baby born within this facility; use of this code necessitates the use of special source of admission codes - see source of admission;

(5) 9--information not available.

[7.1.4.7 NMAC - Rp, 7.1.4.7 NMAC, 11/14/2008; A, 12/01/2010]

7.1.4.8 DATA: [Reserved]

7.1.4.9 STATUS OF DATA: All data and health information collected from data sources shall become the property of the commission upon receipt.

[7.1.4.9 NMAC - Rp, 7.1.4.9 NMAC, 11/14/2008]

7.1.4.10 DATA REPORTING BY LICENSED NONFEDERAL GENERAL AND SPECIALTY INPATIENT HEALTH CARE FACILITIES:

A. **Schedule for reporting:** Beginning with the first quarter of 2011 (January 1-March 31), all licensed nonfederal general and specialty inpatient health care facilities in New Mexico shall submit to the commission on a quarterly basis the data required by this rule, in accordance with the following schedule:

Reporting period	**Report due to the commission**	**Commission returns integrity and validation errors**	**Final corrected report due to the commission**
January 1 - March 31	June 30	July 31	August 30
April 1 - June 30	September 30	October 30	November 30
July 1 - September 30	December 31	January 30 of the following year	February 28 of the following year
October 1 - December 31	March 31 of the following year	April 30 of the following year	May 31 of the following year

B. **Pursuant to the electronic reporting requirements in 7.1.4.11 NMAC, submit the data as a fixed-width ASCII text (flat) file. Follow the record layout specifications, provided by the commission, for field placement and lengths (field lengths are maximum values).**

C. **Data required to be reported:** All licensed nonfederal general and specialty inpatient health care facilities in New Mexico shall report to the commission the following data elements, in the record layout provided by the commission:

(1) admission hour;
(2) attending physician NPI;
(3) birth weight;
(4) discharge hour;
(5) 1st E-code, left justified;
(6) 2nd E-code, left justified;
(7) 3rd E-code, left justified;
(8) medicare provider number, left justified;
(9) New Mexico state license number left justified;
(10) operating physician NPI;
(11) patient principal diagnosis code (ICD-9-CM) left justified;
(12) patient 2nd diagnosis code (ICD-9-CM) left justified;
(13) patient 3rd diagnosis code (ICD-9-CM) left justified;
(14) patient 4th diagnosis code (ICD-9-CM) left justified;
(15) patient 5th diagnosis code (ICD-9-CM) left justified;
(16) patient 6th diagnosis code (ICD-9-CM) left justified;
(17) patient 7th diagnosis code (ICD-9-CM) left justified;
(18) patient 8th diagnosis code (ICD-9-CM) left justified;
(19) patient 9th diagnosis code (ICD-9-CM) left justified;
(20) patient 10th diagnosis code (ICD-9-CM) left justified;
(21) patient 11th diagnosis code (ICD-9-CM) left justified;
(22) patient 12th diagnosis code (ICD-9-CM) left justified;
(23) patient 13th diagnosis code (ICD-9-CM) left justified;
(24) patient 14th diagnosis code (ICD-9-CM) left justified;
(25) patient 15th diagnosis code (ICD-9-CM) left justified;
(26) patient 16th diagnosis code (ICD-9-CM) left justified;
(27) patient 17th diagnosis code (ICD-9-CM) left justified;
(28) patient 18th diagnosis code (ICD-9-CM) left justified;
(29) patient principal diagnosis code, present on admission, left justified;
(30) patient 2nd diagnosis code, present on admission, left justified;
(31) patient 3rd diagnosis code, present on admission, left justified;
(32) patient 4th diagnosis code, present on admission, left justified;
(33) patient 5th diagnosis code, present on admission, left justified;
(34) patient 6th diagnosis code, present on admission, left justified;
(35) patient 7th diagnosis code, present on admission, left justified;
(36) patient 8th diagnosis code, present on admission, left justified;

(37) patient 9th diagnosis code, present on admission, left justified;
(38) patient 10th diagnosis code, present on admission, left justified;
(39) patient 11th diagnosis code, present on admission, left justified;
(40) patient 12th diagnosis code, present on admission, left justified;
(41) patient 13th diagnosis code, present on admission, left justified;
(42) patient 14th diagnosis code, present on admission, left justified;
(43) patient 15th diagnosis code, present on admission, left justified;
(44) patient 16th diagnosis code, present on admission, left justified;
(45) patient 17th diagnosis code, present on admission, left justified;
(46) patient 18th diagnosis code, present on admission, left justified;
(47) patient principal procedure code, left justified;
(48) patient 2nd procedure code, left justified;
(49) patient 3rd procedure code, left justified;
(50) patient 4th procedure code, left justified;
(51) patient 5th procedure code, left justified;
(52) patient 6th procedure code, left justified;
(53) procedure date for patient principal procedure code (mmddyyyy);
(54) procedure date for patient 2nd procedure code (mmddyyyy);
(55) procedure date for patient 3rd procedure code (mmddyyyy);
(56) procedure date for patient 4th procedure code (mmddyyyy);
(57) procedure date for patient 5th procedure code (mmddyyyy);
(58) procedure date for patient 6th procedure code (mmddyyyy);
(59) patient admission date (mmddyyyy);
(60) patient street address, left justified;
(61) patient city, left justified;
(62) patient county, left justified;
(63) patient state, left justified;
(64) patient zip code, left justified;
(65) patient control number, left justified;
(66) patient date of birth (mmddyyyy);
(67) patient diagnosis related group (DRG) code;
(68) patient discharge date (mmddyyyy);
(69) patient EMS ambulance run number, left justified;
(70) patient race;
(71) patient ethnicity;
(72) patient tribal affiliation;
(73) patient first name, left justified;
(74) patient last name, left justified;
(75) patient middle initial;
(76) patient medicaid I.D. number;
(77) patient medical record number, left justified;
(78) patient social security number;
(79) patient status;
(80) primary payer category, right justified;
(81) primary payer identification name, left justified;
(82) primary payer type, right justified;
(83) provider zip code, left justified;
(84) secondary payer category, right justified;
(85) secondary payer identification name, left justified;
(86) secondary payer type;
(87) sex of patient;
(88) source of admission;
(89) total charges, right justified;
(90) traffic crash report number, left justified;
(91) type of admission.

D. **Data reporting requirements for New Mexico human services department's medicaid system:** The New Mexico human service department's medicaid system shall provide all data listed by cooperative agreement between the commission and the human services department, pursuant to the reporting schedule contained in Subsection A of 7.1.4.10 NMAC.

E. **Data reporting requirements for the medicare (part A) fiscal intermediary:** The medicare (part A) fiscal intermediary shall provide all data mutually agreed upon in accordance with law between the commission and the fiscal intermediary, pursuant to the reporting schedule contained in Subsection A of 7.1.4.10 NMAC.

F. **Annual financial statements:** All licensed nonfederal general and specialty inpatient health care facilities shall submit annual audited financial statements to the commission. If the owners of such facilities obtain one audit covering more than one facility, combined annual audited financial statements may be submitted in compliance with this section. Facilities reporting in combined annual audited financial statements must also submit annual unaudited, individual facility financial statements to the commission. These reports shall be submitted no later than the end of the calendar year following the statement year.
[7.1.4.10 NMAC - Rp, 7.1.4.10 NMAC, 11/14/2008; A, 12/01/2010]

7.1.4.11 ELECTRONIC REPORTING REQUIREMENTS: Starting with 2011 data, all data providers shall submit the required quarterly discharge data pursuant to the reporting schedule contained in Subsection A of 7.1.4.10 NMAC and all final corrected reports, for the full year's worth of data, are due no later than May 31of the following year. Submit data by electronic media, which includes CD or DVD or by direct electronic transmission, in an ASCII file format, per the record layout and instruction provided by the commission. Label all data with the following information: type of data, hospital name and license number, year, file name, point of contact and telephone number. Please mail data to New Mexico Health Policy Commission, ATTN: State Reporting Data Steward, 1190 St. Francis Drive, Suite N3060, Santa Fe, NM 87505.
[7.1.4.11 NMAC - Rp, 7.1.4.11 NMAC, 11/14/2008; A, 12/01/2010]

7.1.4.12 REPORTING EXEMPTIONS: Upon written application to the commission, the commission may grant a health care facility a temporary exemption, not to exceed two reporting quarters, from the schedule required by Subsection A of 7.1.4.10 NMAC. Temporary exemption from reporting does not excuse the health care facility from reporting the data from the exempted period. Upon resumption of the regular reporting schedule the health care facility shall promptly report data for the exempted period.
[7.1.4.12 NMAC - Rp, 7.1.4.12 NMAC, 11/14/2008]

7.1.4.13 PENALTIES FOR RULE VIOLATION: Failure to comply with any of the reporting requirements in this rule may result in injunctive relief and a civil penalty not to exceed $1,000 per violation, as provided by the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.
[7.1.4.13 NMAC - Rp, 7.1.4.13 NMAC, 11/14/2008]

HISTORY OF 7.1.4 NMAC: The material in this part was derived from that previously filed with the state records center under:
HED 90-2 (OP&E), The New Mexico Health Information System Act Regulations, 2/23/1990.
HED 90-9, (OP&E) New Mexico Health Information System Act Regulations, 12/4/1990.
HPC Rule No. 94-1, Regulations Governing the State of New Mexico Health Information System Act, 12/16/1994.

History of Repealed Material:
7 NMAC 1.1, Data Reporting Requirements for Health Care Facilities, (filed 8/14/1997) repealed 03/31/2008.
7.4.1 NMAC, Data Reporting Requirements for Health Care Facilities (filed 3/13/2008) repealed 11/14/2008.

Other History:
HPC Rule 94-1 New Mexico Health Information System Act Requirements (filed 12/16/1994) renumbered, reformatted and replaced by 7 NMAC 1.1, Data Reporting Requirements for Health Care Facilities, 08/15/1996.
7 NMAC 1.1, Data Reporting Requirements for Health Care Facilities, (filed 8/02/1996) replaced by 7 NMAC 1.1, Data Reporting Requirements for Health Care Facilities, effective 08/30/1997.
7 NMAC 1.1, Data Reporting Requirements for Health Care Facilities, (filed 8/14/1997) renumbered, reformatted and replaced by 7.1.4 NMAC, Data Reporting Requirements for Health Care Facilities, effective 03/31/2008.

7.4.1 NMAC, Data Reporting Requirements for Health Care Facilities (filed 3/13/2008) replaced by 7.1.4 NMAC, Data Reporting Requirements for Health Care Facilities, effective 11/14/2008.