TITLE 7 HEALTH
CHAPTER 1 HEALTH GENERAL PROVISIONS
PART 27 HEALTH INFORMATION SYSTEM REPORTING REQUIREMENTS FOR HEALTHCARE FACILITIES AND ACCESS TO DATA AND REPORTS

7.1.27.1 ISSUING AGENCY: New Mexico Department of Health.
[7.1.27.1 NMAC - N, 12/31/2012]

7.1.27.2 SCOPE: This rule applies to all licensed inpatient and outpatient general and specialty health care facilities located within New Mexico.
[7.1.27.2 NMAC - N, 12/31/2012]

7.1.27.3 STATUTORY AUTHORITY: This rule is promulgated pursuant to Subsections 24-14A-3D (5) and (6); 24-14A-5(A) through C; 24-14A-8(A) and B; and 24-14A-9 of the Health Information System (HIS) Act, Sections 24-14A-1 to -10, NMSA 1978.
[7.1.27.3 NMAC - N, 12/31/2012]

7.1.27.4 DURATION: Permanent.
[7.1.27.4 NMAC - N, 12/31/2012]

7.1.27.5 EFFECTIVE DATE: December 31, 2012, unless another date is cited at the end of a section.
[7.1.27.5 NMAC - N, 12/31/2012]

7.1.27.6 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 HIS Act, Sections 24-14A-1 to -10, NMSA 1978.
[7.1.27.6 NMAC - N, 12/31/2012]

7.1.27.7 DEFINITIONS: In addition to the definitions in the HIS Act, Sections 24-14A-1 to -10, NMSA 1978, the following terms have the following meaning for purposes of this rule.

A. All definitions that begin with the letter A.

(1) **Accident state** means the two-digit state abbreviation where the accident occurred when services are related to an auto accident.

(2) **Admission hour** means the hour and minute the patient was admitted as an inpatient, coded in military time (e.g., 2:45 p.m. is represented as 1445).

(3) **Aggregate analysis** means information in report form that contains data combined in a manner which precludes specific identification of a single patient or health care provider.

(4) **Annual permanent database** means one calendar year of permanent hospital inpatient discharge data or any other database collected under the HIS Act that is deemed complete by division staff.

(5) **Attending physician NPI** means 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.

B. All definitions that begin with the letter B. **Birth weight** means weight of newborns coded in grams.

C. All definitions that begin with the letter C.

(1) **Centers for medicare and medicaid services or CMS** means the United States federal agency which administers medicare, medicaid, and the state children's health insurance programs.

(2) **1st condition code, 2nd condition code, 3rd condition code, 4th condition code, 5th condition code, 6th condition code, 7th condition code, 8th condition code, 9th condition code, 10th condition code, 11th condition code** means the codes used to identify conditions or events relating to the billing claim that may affect processing as defined in the form locators 18-28 of the UB-04 manual. (**Usage note: The state requires public health data reporting to indicate that a patient was admitted directly from the facility's emergency room/department. Provider will use the code "P7" to indicate the patient was admitted from the provider facility's emergency room/department**).

D. All definitions that begin with the letter D.

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

(2) **Data source** has the meaning given in Section 24-14A-2 of the HIS Act, 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.

(3) **Database** means a set of data based on individual patient hospital discharge abstract data or any other database collected under the HIS Act.

(4) **Department** means the New Mexico department of health.

(5) **Division** means the epidemiology and response division of the department, P.O. Box 26110, Santa Fe, NM 87502-6110.

(6) **Discharge hour** means the hour and minute the patient was discharged as an inpatient, coded in military time (e.g., 2:45 p.m. is represented as 1445).

(7) **Durable medical equipment or DME** means medical equipment used in the home to aid in a better quality of living.

E. All definitions that begin with the letter E.

(1) **1st e-code** means the first code for external causes of injury, poisoning, or adverse effect. (Usage note: If a patient has an injury diagnosis in a range of ICD-9-CM 800-999, an e-code is required. This is the primary (first-listed) external cause of injury).

(2) **2nd e-code** means the second code for external causes of injury, poisoning, or adverse effect.

(3) **3rd e-code** means the third code for external causes of injury, poisoning, or adverse effect.

F. All definitions that begin with the letter F. **Federal agency** means any agency, department, bureau, board, division, institution, or other organization of the United States government.

G. All definitions that begin with the letter G.

H. All definitions that begin with the letter H.

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

(2) **Health care professional** means any individual licensed, certified, or otherwise authorized or permitted by law to provide health care in the practice of a profession.

(3) **Health care provider** means any individual, corporation, partnership, organization, facility, institution, or other entity licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession.

(4) **Health information system or HIS** means the health information system established by the Health Information System Act, Sections 24-14A-1 to 24-14A-10, NMSA 1978.

(5) **HIS advisory committee** means individuals from the division pursuant to Subsection 24-14A-3.1 of the HIS Act.

(6) **Health Information System Act (HIS Act)** means the Health Information System Act, Sections 24-14A-1 to 24-14A-10, NMSA 1978.

(7) **Health insurance prospective payment system (HIPPS) rate code** means the three-digit codes that represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types. For the payment systems that use HIPPS codes, clinical assessment data is the basic input used to determine which case-mix group applies to a particular patient. A standard patient assessment instrument is interpreted by case-mix grouping software algorithms, which assign the case mix group. For payment purposes, at least one HIPPS code is defined to represent each case-mix group. These HIPPS codes are reported on claims to insurers and reported in form locator 71 of the UB-04 manual.

I. All definitions that begin with the letter I.

(1) **ICD-9-CM** is the international classification of disease, ninth revision, clinical modification for clinical diagnosis and procedure coding (October 2011) American medical association.

(2) **ICD-10-CM** is the international classification of disease, 10th revision, clinical modification for clinical diagnosis coding.

(3) **ICD-10-PCS** is the international classification of disease, 10th revision, clinical modification for procedure coding.

(4) **Identifier** means any information that reveals the identity of, or could reasonably be used to reveal the identity of, a single patient, or health care professional, but does not include a number assigned to a single patient for the purpose of conducting longitudinal or linking studies.

(5) **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.

(6) **Inpatient rehabilitation facility or IRF** is an inpatient rehabilitation hospital or part of a rehabilitation hospital, which provides an intensive rehabilitation program for inpatients.

(7) **ISO 3166** is the codes for representation of names of countries issued by the American national standards institute (ANSI) (latest release).

J. All definitions that begin with the letter J.

K. All definitions that begin with the letter K.

L. All definitions that begin with the letter L. **Long-term care hospital or LTCH** means an acute care hospital certified by the centers for medicare and medicaid services (CMS) that provide rehabilitative, restorative, or on-going skilled nursing care to patients or residents in need of assistance with activities of daily living. Long-term care facilities include nursing homes, rehabilitation facilities, inpatient behavioral health facilities, and long-term chronic care hospitals.

M. All definitions that begin with the letter M. **Medicare provider number** means the six digit number assigned by medicare to the data source providing the reported service(s).

N. All definitions that begin with the letter N.

(1) **National provider identifier (NPI)** means the 10-digit NPI from the national plan and provider enumeration system (NPPES).

(2) **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).

(3) **National uniform billing committee or NUBC** is an entity formed by the American hospital association (AHA) in 1975, which includes participation by all major national provider and payer organizations and develops single billing forms and standard data sets that are used nationwide by institutional providers and payers for handling health care claims.

O. All definitions that begin with the letter O.

(1) **Operating physician NPI** means 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.

(2) **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.

P. All definitions that begin with the letter P.

(1) **Patient** means a person who has received or is receiving health care.

(2) **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.

(3) **Patient admitting diagnosis code, 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, and patient 18th diagnosis code** means the ICD-9-CM (or ICD-10-CM or subsequent versions of ICD coding) 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.

(4) **Patient city** means the city of the patient's residence at the time of discharge.

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

(6) **Patient country code** means the two-digit alpha-two codes of the patient's residence at the time of discharge, from Part I of the ISO 3166 as required in form locator 9e of the UB-04 manual. (Usage note: Reported only if other than a United States residence).

(7) **Patient county** means the county of the patient's residence at the time of discharge.

(8) **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).

(9) **Patient diagnosis related group (DRG) code** means the diagnostic related group code used for the HIPPS code in form locator 71 of the UB-04 manual.

(10) **Patient diagnostic code qualifier** means the revision number of the international classifications of disease diagnosis codes used to record the diagnoses represented by Paragraph (20) of Subsection P of 7.1.27.7 NMAC.

(a) 9-ICD-9-CM, ninth revision required on claims through September 30, 2013.
(b) 0-ICD-10-CM, 10th revision when implemented.
(c) 1-ICD-11-CM, 11th revision reservation for future reporting requirements.

(11) **Patient's discharge date** means the date the patient was discharged by the provider from the inpatient health care facility. Formatted as "mmddyyyy" (i.e., an admission date of July 1, 1983, would be coded "07011983").

(12) **Patient's emergency medical services (EMS) ambulance run number** means the emergency medical services ambulance run number.

(13) **Patient's ethnicity** means the gross classification of a patient's stated ethnicity, coded as follows:

(a) E1-Hispanic or Latino;
(b) E2-not Hispanic or Latino;
(c) E6-declined;
(d) E7-unknown or unable to obtain.

(14) **Patient's first name** means the first name of the patient.

(15) **Patient's medicaid number** means the patient's unique identification number assigned by medicaid.

(16) **Patient's medical record number** means the medical record number used by the provider to identify the patient.

(17) **Patient's middle initial** means the middle initial of the patient.

(18) **Patient's 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.

(19) **Patient's phone number** means the 10 digit phone number provided by the patient, without section separating characters like dashes, hyphens or slashes (i.e., "5051234567").

(20) **Patient's 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.

(a) Y-yes.
(b) N-no.
(c) U-no information on the record.
(d) W-clinically undetermined.
(e) 1-exempt.

(21) **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's stay.

(22) **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 American Indian and other the race field would be R1R9.

(a) R1-American Indian or Alaska Native.

(b) R2-Asian (including Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese).
(c) R3-Black or African American.
(d) R4-Native Hawaiian or Pacific Islander (including Chamorro and Samoan) .
(e) R5-White.
(f) R6-declined.
(g) R7-unknown or unable to obtain.
(h) R9-other race.

(23) **Patient's social security number** means the nine digit social security number provided by the patient, without section separating characters like dashes, hyphens or slashes (i.e., "123456789").

(24) **Patient's state** means the two-digit state code of the patient's residence at the time of discharge.

(25) **Patient's status** means the code indicating patient's disposition at time of discharge. The codes are:

(a) 01-discharged to home or self care (routine discharge); (usage note: includes discharge to home; home on oxygen if DME only; any other DME only; group home; foster care; independent living and other residential care arrangements; outpatient programs, such as partial hospitalization of outpatient chemical dependency programs);

(b) 02-discharged/transferred to a short-term general hospital for inpatient care;

(c) 03-discharged/transferred to skilled nursing facility (SNF) with medicare certification in anticipation of skilled care; (usage note: medicare-indicates that the patient is discharged/transferred to a medicare certified nursing facility; for hospitals with an approved swing bed arrangement, use code 61-swing bed; for reporting other discharges/transfers to nursing facilities see definitions for codes 04 and 64 in accordance with 7.1.27.7 NMAC);

(d) 04-discharged/transferred to a facility that provides custodial or supportive care; (usage note: includes intermediate care facilities (ICF) if specifically designated at the state level; also used to designate patients that are discharged/transferred to a nursing facility with neither medicare nor medicaid certification and for discharges/transfers to assisted living facilities);

(e) 05-discharged/transferred to a designated cancer center of children's hospital;

(f) 06-discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care; (usage note: report this code when a patient is discharged/transferred to home with a written plan of care (tailored to the patient's medical needs) for home care services; not used for home health services provided by a DME supplier or from a home IV provider for home IV services);

(g) 07-left against medical advice or discontinued care;

(h) 08-reserved for national assignment by the NUBC;

(i) 09-admitted as an inpatient to this hospital; (usage note: this is for use only on medicare outpatient claims; applies only to those medicare outpatient services that begin greater than three days prior to admission and therefore should not be reported for inpatient discharges);

(j) 10-19 reserved for national assignment by the NUBC;

(k) 20-expired;

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

(m) 22-29-reserved for national assignment by the NUBC;

(n) 30-still patient or expected to return for outpatient services; (usage note: used when patient is still within the same facility; typically used when billing for leave of absence days or interim bills);

(o) 31-39-reserved for national assignment by the NUBC;

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

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

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

(s) 43-discharged/transferred to a federal health care facility; (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 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);

(t) 44-49-reserved for national assignment by the NUBC;

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

(v) 51-discharged/transferred to hospice-medical facility (certified) providing hospice level of care;

(w) 52-60-reserved for national assignment by the NUBC;

(x) 61-discharged/transferred within this institution to a hospital based medicare approved swing bed; (usage note: medicare-used for reporting patients discharged/transferred to SNF level of care within the hospital's approved swing bed arrangement);

(y) 62-discharged/transferred to an IRF including rehabilitation distinct part units of a hospital;

(z) 63-discharged/transferred to a LTCH; (usage note: for hospitals that meet the medicare criteria for LTCH certification);

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

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

(cc) 66-discharged/transferred to a critical access hospital (CAH);

(dd) 67-69 reserved for national assignment by the NUBC;

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

(ff) 71-99-reserved for national assignment by the NUBC.

(26) **Patient's 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.

(27) **Patient's tribal affiliation** means the classification(s) of patient's stated New Mexico tribal affiliation, if stated race indicates American Indian. 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 T1T10:

(a) T1-Acoma pueblo;
(b) T2-Cochiti pueblo;
(c) T3-Isleta pueblo;
(d) T4-Jemez pueblo;
(e) T5-Jicarilla Apache nation;
(f) T6-Kewa/Santo Domingo pueblo;
(g) T7-Laguna pueblo;
(h) T8-Mescalero Apache nation;
(i) T9-Nambe pueblo;
(j) T10-Navajo nation;
(k) T11-Ohkay Owingeh pueblo;
(l) T12-Picuris pueblo;
(m) T13-Pojoaque pueblo;
(n) T14-San Felipe pueblo;
(o) T15-San Ildefonso pueblo;
(p) T16-Sandia pueblo;
(q) T17-Santa Ana pueblo;
(r) T18-Santa Clara pueblo;
(s) T19-Taos pueblo;
(t) T20-Tesuque pueblo;
(u) T21-Zia pueblo;
(v) T22-Zuni pueblo;
(w) T100-other tribal affiliation;
(x) T200-declined;
(y) T300-unknown.

(28) **Patient's 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).

(29) **Permanent hospital inpatient discharge data** means hospital inpatient discharge data contained in a data set created by the division after submitting data the provider has either (1) reviewed and approved a division statistical report based on the data provider's patient discharges; or (2) been provided a 30-day period to review the division's statistical report.

(30) **Point of origin for admission or visit** means the source of referral for this admission.

(a) **Adults and pediatrics:** Source of admission codes for adults and pediatrics are:

(i) 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 health maintenance organization (HMO) physician (this includes patients coming from home, a physician's office, or workplace;

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

(iii) 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);

(iv) 5-transfer from SNF or ICF-the patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident;

(v) 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);

(vi) 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);

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

(viii) A-reserved for national assignment;

(ix) 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;

(x) 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);

(xi) 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;

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

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

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

(ii) 6-born outside of this facility-a baby born outside of this facility.

(31) **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:

(a) 1-**medicare** is the primary payer from which the provider might expect some payment;

(b) 2-**medicaid** is the primary payer from which the provider might expect some payment;

(c) 3-**other government (federal/state/local**) is the primary payer from which the provider might expect some payment (excluding department of corrections);

(d) 4-**department of corrections** is the primary payer from which the provider might expect some payment;

(e) 5-**private health insurance** is the primary payer from which the provider might expect some payment;

(f) 6-**blue cross/blue shield** is the primary payer from which the provider might expect some payment;

(g) 7-**managed care, unspecified** is the primary payer from which the provider might expect some payment (to be used only if one cannot distinguish public from private);

(h) 8-**no payment** from an organization, agency, program or private payer is listed as the primary payer;

(i) 9-**miscellaneous/other** primary payer source from which the provider might expect some payment.

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

(33) **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):

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

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

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

(d) 88-**unknown**.

(34) **Procedure code qualifier** means the revision number of the international classifications of disease diagnosis codes used to record the procedure represented by Paragraph (21) of Subsection P of 7.1.27.7 NMAC.

(a) 9-ICD-9-PCS, ninth revision required on claims through September 30, 2013.

(b) 0-ICD-10-PCS, 10th revision to take effect October 1, 2013 or such later date as required by the CMS.

(c) 1-ICD-11-PCS, 11th revision reservation for future reporting requirements.

(35) **Procedure date for patient's 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).

(36) **Proprietary information** means confidential technical information, administrative information, or business methods that are the property of the data provider and are perceived to confer a competitive position in the health care market by not being openly known by competitors.

(37) **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 (i.e., 12345 or 123456789).

Q. All definitions that begin with the letter Q.

R. All definitions that begin with the letter R.

(1) **Requestor** means a person who makes a request for access to health information system data or reports pursuant to this rule.

(2) **Routine report** means a report that contains information of use to the general public that is issued by the division on its own initiative and not in response to a specific, individualized request.

(3) **1st revenue code, 2nd revenue code, 3rd revenue code, 4th revenue code, 5th revenue code, 6th revenue code, 7th revenue code, 8th revenue code, 9th revenue code, 10th revenue code, 11th revenue code, 12th revenue code, 13th revenue code, 14th revenue code, 15th revenue code, 16th revenue code, 17th revenue code, 18th revenue code, 19th revenue code, 20th revenue code, 21st revenue code, and 22nd revenue code** means the four-digt revenue codes that identify the specific accommodation, ancillary service or unique billing calculations, or arrangements made during the patient's stay.

(4) **1st revenue description, 2nd revenue description, 3rd revenue description, 4th revenue description, 5th revenue description, 6th revenue description, 7th revenue description, 8th revenue description, 9th revenue description, 10th revenue description, 11th revenue description, 12th revenue description, 13th revenue description, 14th revenue description, 15th revenue description, 16th revenue description, 17th revenue description, 18th revenue description, 19th revenue description, 20th revenue description, 21st revenue description, and 22nd revenue description** means the revenue standard abbreviated descriptions that identify the specific accommodation, ancillary service or unique billing calculations, or arrangements made during the patient's stay.

(5) **1st revenue line item charges, 2nd revenue line item charges, 3rd revenue line item charges, 4th revenue line item charges, 5th revenue line item charges, 6th revenue line item charges, 7th revenue line item charges, 8th revenue line item charges, 9th revenue line item charges, 10th revenue line item charges, 11th revenue line item charges, 12th revenue line item charges, 13th revenue line item charges, 14th revenue line item charges, 15th revenue line item charges, 16th revenue line item charges, 17th revenue line item charges, 18th revenue line item charges, 19th revenue line item charges, 20th revenue line item charges, 21st revenue line item charges, and 22nd revenue line item charges** means the revenue line item charges, rounded to the whole dollar, for the specific accommodation, ancillary service or unique billing calculations, or arrangements made during the patient's stay.

(6) **1st revenue non-covered charges, 2nd revenue non-covered charges, 3rd revenue non-covered charges, 4th revenue non-covered charges, 5th revenue non-covered charges, 6th revenue non-covered charges, 7th revenue non-covered charges, 8th revenue non-covered charges, 9th revenue non-covered charges, 10th revenue non-covered charges, 11th revenue non-covered charges, 12th revenue non-covered charges, 13th revenue non-covered charges, 14th revenue non-covered charges, 15th revenue non-covered charges, 16th revenue non-covered charges, 17th revenue non-covered charges, 18th revenue non-covered charges, 19th revenue non-covered charges, 20th revenue non-covered charges, 21st revenue non-covered charges, and 22nd revenue non-covered charges** means the revenue non-covered charges, rounded to the

whole dollar, for the specific accommodation, ancillary service or unique billing calculations, or arrangements made during the patient's stay.

(7) **1st revenue service date, 2nd revenue service date, 3rd revenue service date, 4th revenue service date, 5th revenue service date, 6th revenue service date, 7th revenue service date, 8th revenue service date, 9th revenue service date, 10th revenue service date, 11th revenue service date, 12th revenue service date, 13th revenue service date, 14th revenue service date, 15th revenue service date, 16th revenue service date, 17th revenue service date, 18th revenue service date, 19th revenue service date, 20th revenue service date, 21st revenue service date, and 22nd revenue service date** means the revenue service dates that the specific accommodation, ancillary service or unique billing calculations, or arrangements occurred on.

(8) **1st revenue service units, 2nd revenue service units, 3rd revenue service units, 4th revenue service units, 5th revenue service units, 6th revenue service units, 7th revenue service units, 8th revenue service units, 9th revenue service units, 10th revenue service units, 11th revenue service units, 12th revenue service units, 13th revenue service units, 14th revenue service units, 15th revenue service units, 16th revenue service units, 17th revenue service units, 18th revenue service units, 19th revenue service units, 20th revenue service units, 21st revenue service units, and 22nd revenue service units** means the quantitative measure of services rendered by the revenue category to or for the patient to include items such as number of accommodation dates, miles, pints of blood, renal dialysis treatments, etc.

S. All definitions that begin with the letter S.

(1) **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:

(a) 1-**medicare** is the secondary payer from which the provider might expect some payment;

(b) 2-**medicaid** is the secondary payer from which the provider might expect some payment;

(c) 3-**other government (federal/state/local**) is the secondary payer from which the provider might expect some payment (excluding department of corrections);

(d) 4-**department of corrections** is the secondary payer from which the provider might expect some payment;

(e) 5-**private health insurance** is the secondary payer from which the provider might expect some payment;

(f) 6-**blue cross/blue shield** is the secondary payer from which the provider might expect some payment;

(g) 7-**managed care, unspecified** is the secondary payer from which the provider might expect some payment (to be used only if one cannot distinguish public from private);

(h) 8-**no payment** from an organization, agency, program, or private payer is listed as the secondary payer;

(i) 9-**miscellaneous/other** secondary payer source from which the provider might expect some payment.

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

(3) **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):

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

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

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

(d) 88-**unknown**.

(4) **Secretary** means the cabinet secretary of the department of health.

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

(a) F-female;

(b) M-male;

(c) U-unknown.

(6) **Skilled nursing facility or SNF** means a type of nursing home recognized by the medicare and medicaid systems as meeting long-term health care needs for individuals who the potential to function independently after a limited period of care.

(7) **State agency** means any agency, department, division, bureau, board, commission, institution, or other organization of a state government, including state educational institutions and political subdivisions. "State agency" does not include any health care facility operated by a state agency.

T. All definitions that begin with the letter T.

(1) **Tertiary payer category** means one of the following broad categories assigned by the data provider to the payment source identified in the tertiary payer identification name field:

(a) 1-**medicare** is the tertiary payer from which the provider might expect some payment;

(b) 2-**medicaid** is the tertiary payer from which the provider might expect some payment;

(c) 3-**other government (federal/state/local**) is the tertiary payer from which the provider might expect some payment (excluding the department of corrections);

(d) 4-**department of corrections** is the tertiary payer from which the provider might expect some payment;

(e) 5-**private health insurance** is the tertiary payer from which the provider might expect some payment;

(f) 6-**blue cross/blue shield** is the tertiary payer from which the provider might expect some payment;

(g) 7-**managed care, unspecified** is the tertiary payer from which the provider might expect some payment (to be used only if one cannot distinguish public from private);

(h) 8-**no payment** from an organization, agency, program, or private payer is listed as the tertiary payer;

(i) 9-**miscellaneous/other** tertiary payer source from which the provider might expect some payment.

(3) **Tertiary payer identification name** means the name identifying a tertiary payer from which the provider might expect some payment for the reported service(s).

(4) **Tertiary payer type** means the type of tertiary payer as defined below from which the provider might expect some payment for the reported service(s):

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

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

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

(d) 88-**unknown**.

(5) **Total charges** means an 11 digit number rounded to the whole dollar for the total charges for all inpatient services reported. This is the sum of all revenue service line charges.

(6) **Traffic crash report number** means the six digit number of the traffic crash/accident report form.

(7) **Type of admission** means an inpatient code indicating the priority of the admission. Type of admission codes are:

(a) 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;

(b) 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;

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

(d) 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;

(e) 9-information not available.

(8) **Type of bill** means the specific type of bill code indicating the type of billing for inpatient services.

U. All definitions that begin with the letter U.

(1) **UB-04 manual** is the official NUBC data specifications manual for (© AHA) issued by the NUBC.

V. All definitions that begin with the letter V.

W. All definitions that begin with the letter W.

X. All definitions that begin with the letter X.

Y. All definitions that begin with the letter Y.

Z. All definitions that begin with the letter Z.

[7.1.27.7 NMAC - N, 12/31/2012]

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

[7.1.27.8 NMAC - N, 12/31/2012]

7.1.27.9 DATA REPORTING BY LICENSED NON-FEDERAL GENERAL AND SPECIALTY INPATIENT HEALTH CARE FACILITIES:

A. **Schedule for reporting:** Beginning with the first quarter of 2013 (January 1-March 31), all licensed non-federal general and specialty inpatient health care facilities in New Mexico shall submit the reporting period discharges to the division on a quarterly basis the data required by this rule, in accordance with the following schedule:

Reporting period	**Report due to the division (95% discharges)**	**Division returns integrity and validation errors**	**Final corrected report due to the division (100% discharges)**
January 1-March 31	May 31	June 15	June 30
April 1-June 30	August 30	September 15	September 30
July 1-September 30	November 30	December 15	December 31
October 1-December 31	February 28 of the following year	March 15 of the following year	March 31 of the following year

B. **Pursuant to the electronic reporting requirements in 7.1.27.10 NMAC, submit the data as a fixed-width ASCII text (flat) file. Follow the record layout specifications, provided by the division, for field placement and lengths (field lengths are maximum values and shall contain blank spaces as fillers for values less than the maximum length).**

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

(1) New Mexico state license number, left justified;
(2) medicare provider number, left justified;
(3) provider zip code (five or nine digits), left justified;
(4) admission hour (military time);
(5) patient's admission date (mmddyyyy);
(6) point of origin (1 to 9, a, d, e, and f);
(7) type of admission (1 to 4, 9);
(8) patient's ems ambulance run number, left justified;
(9) traffic crash report number, left justified;
(10) accident state (two-digit code), left justified;
(11) patient's medical record number, left justified;
(12) patient's medicaid id number;
(13) patient's control number, left justified;
(14) birth weight (grams);
(15) attending physician NPI (assigned by medicare);
(16) operating physician NPI (assigned by medicare);
(17) discharge hour (military time);
(18) patient's discharge date (mmddyyyy);
(19) patient's status (01 to 99);
(20) primary payer category (1 to 10, 88), right justified;
(21) primary payer identification name, left justified;
(22) primary payer type (1 to 3, 88), right justified;
(23) secondary payer category (1 to 10, 88), right justified;
(24) secondary payer identification name, left justified;
(25) secondary payer type (1 to 3, 88), right justified;
(26) tertiary payer category (1 to 10, 88), right justified;
(27) tertiary payer identification name, left justified;
(28) tertiary payer type (1 to 3, 88), right justified;
(29) 1st condition code, left justified;

(30) 2nd condition code, left justified;
(31) 3rd condition code, left justified;
(32) 4th condition code, left justified;
(33) 5th condition code, left justified;
(34) 6th condition code, left justified;
(35) 7th condition code, left justified;
(36) 8th condition code, left justified;
(37) 9th condition code, left justified;
(38) 10th condition code, left justified;
(39) 11th condition code, left justified;
(40) 1st revenue code, left justified;
(41) 1st revenue code description, left justified;
(42) 1st revenue code service date (mmddyyyy), left justified;
(43) 1st revenue code service units, right justified;
(44) 1st revenue code line item charges, right justified;
(45) 1st revenue code non-covered charges, right justified;
(46) 2nd revenue code, left justified;
(47) 2nd revenue code description, left justified;
(48) 2nd revenue code service date (mmddyyyy), left justified;
(49) 2nd revenue code service units, right justified;
(50) 2nd revenue code line item charges, right justified;
(51) 2nd revenue code non-covered charges, right justified;
(52) 3rd revenue code description, left justified;
(53) 3rd revenue code service date (mmddyyyy), left justified;
(54) 3rd revenue code service units, right justified;
(55) 3rd revenue code line item charges, right justified;
(56) 3rd revenue code non-covered charges, right justified;
(57) 4th revenue code, left justified;
(58) 4th revenue code description, left justified;
(59) 4th revenue code service date (mmddyyyy), left justified;
(60) 4th revenue code service units, right justified;
(61) 4th revenue code line item charges, right justified;
(62) 4th revenue code non-covered charges, right justified;
(63) 5th revenue code, left justified;
(64) 5th revenue code description, left justified;
(65) 5th revenue code service date (mmddyyyy), left justified;
(66) 5th revenue code service units, right justified;
(67) 5th revenue code line item charges, right justified;
(68) 5th revenue code non-covered charges, right justified;
(69) 6th revenue code, left justified;
(70) 6th revenue code description, left justified;
(71) 6th revenue code service date (mmddyyyy), left justified;
(72) 6th revenue code service units, right justified;
(73) 6th revenue code line item charges, right justified;
(74) 6th revenue code non-covered charges, right justified;
(75) 7th revenue code, left justified;
(76) 7th revenue code description, left justified;
(77) 7th revenue code service date (mmddyyyy), left justified;
(78) 7th revenue code service units, right justified;
(79) 7th revenue code line item charges, right justified;
(80) 7th revenue code non-covered charges, right justified;
(81) 8th revenue code, left justified;
(82) 8th revenue code description, left justified;
(83) 8th revenue code service date (mmddyyyy), left justified;
(84) 8th revenue code service units, right justified;
(85) 8th revenue code line item charges, right justified;

(86) 8th revenue code non-covered charges, right justified;
(87) 9th revenue code, left justified;
(88) 9th revenue code description, left justified;
(89) 9th revenue code service date (mmddyyyy), left justified;
(90) 9th revenue code service units, right justified;
(91) 9th revenue code line item charges, right justified;
(92) 9th revenue code non-covered charges, right justified;
(93) 10th revenue code, left justified;
(94) 10th revenue code description, left justified;
(95) 10th revenue code service date (mmddyyyy), left justified;
(96) 10th revenue code service units, right justified;
(97) 10th revenue code line item charges, right justified;
(98) 10th revenue code non-covered charges, right justified;
(99) 11th revenue code, left justified;
(100) 11th revenue code description, left justified;
(101) 11th revenue code service date (mmddyyyy), left justified;
(102) 11th revenue code service units, right justified;
(103) 11th revenue code line item charges, right justified;
(104) 11th revenue code non-covered charges, right justified;
(105) 12th revenue code, left justified;
(106) 12th revenue code description, left justified;
(107) 12th revenue code service date (mmddyyyy), left justified;
(108) 12th revenue code service units, right justified;
(109) 12th revenue code line item charges, right justified;
(110) 12th revenue code non-covered charges, right justified;
(111) 13th revenue code, left justified;
(112) 13th revenue code description, left justified;
(113) 13th revenue code service date (mmddyyyy), left justified;
(114) 13th revenue code service units, right justified;
(115) 13th revenue code line item charges, right justified;
(116) 13th revenue code non-covered charges, right justified;
(117) 14th revenue code, left justified;
(118) 14th revenue code description, left justified;
(119) 14th revenue code service date (mmddyyyy), left justified;
(120) 14th revenue code service units, right justified;
(121) 14th revenue code line item charges, right justified;
(122) 14th revenue code non-covered charges, right justified;
(123) 15th revenue code, left justified;
(124) 15th revenue code description, left justified;
(125) 15th revenue code service date (mmddyyyy), left justified;
(126) 15th revenue code service units, right justified;
(127) 15th revenue code line item charges, right justified;
(128) 15th revenue code non-covered charges, right justified;
(129) 16th revenue code, left justified;
(130) 16th revenue code description, left justified;
(131) 16th revenue code service date (mmddyyyy), left justified;
(132) 16th revenue code service units, right justified;
(133) 16th revenue code line item charges, right justified;
(134) 16th revenue code non-covered charges, right justified;
(135) 17th revenue code, left justified;
(136) 17th revenue code description, left justified;
(137) 17th revenue code service date (mmddyyyy), left justified;
(138) 17th revenue code service units, right justified;
(139) 17th revenue code line item charges, right justified;
(140) 17th revenue code non-covered charges, right justified;
(141) 18th revenue code, left justified;

(142) 18th revenue code description, left justified;
(143) 18th revenue code service date (mmddyyyy), left justified;
(144) 18th revenue code service units, right justified;
(145) 18th revenue code line item charges, right justified;
(146) 18th revenue code non-covered charges, right justified;
(147) 19th revenue code, left justified;
(148) 19th revenue code description, left justified;
(149) 19th revenue code service date (mmddyyyy), left justified;
(150) 19th revenue code service units, right justified;
(151) 19th revenue code line item charges, right justified;
(152) 19th revenue code non-covered charges, right justified;
(153) 20th revenue code, left justified;
(154) 20th revenue code description, left justified;
(155) 20th revenue code service date (mmddyyyy), left justified;
(156) 20th revenue code service units, right justified;
(157) 20th revenue code line item charges, right justified;
(158) 20th revenue code non-covered charges, right justified;
(159) 21st revenue code, left justified;
(160) 21st revenue code description, left justified;
(161) 21st revenue code service date (mmddyyyy), left justified;
(162) 21st revenue code service units, right justified;
(163) 21st revenue code line item charges, right justified;
(164) 21st revenue code non-covered charges, right justified;
(165) 22nd revenue code, left justified;
(166) 22nd revenue code description, left justified;
(167) 22nd revenue code service date (mmddyyyy), left justified;
(168) 22nd revenue code service units, right justified;
(169) 22nd revenue code line item charges, right justified;
(170) 22nd revenue code non-covered charges, right justified;
(171) patient's last name, left justified;
(172) patient's middle initial;
(173) patient's social security number;
(174) patient's street address, left justified;
(175) patient's city, left justified;
(176) patient's county, left justified;
(177) patient's state, left justified;
(178) patient's zip code (five or nine digits), left justified;
(179) patient's date of birth (mmddyyyy);
(180) patient's race-multiple (r1 to r7. r9);
(181) patient's ethnicity (e1, e2, e6, e7);
(182) patient's tribal affiliation-up to five (t1 to t22, t100, t200, t300);
(183) sex of patient (m, f, u);
(184) patient's phone number, left justified;
(185) patient's admitting diagnosis code, left justified;
(186) patient's principal diagnosis code, left justified;
(187) patient's 2nd diagnosis code, left justified;
(188) patient's 3rd diagnosis code, left justified;
(189) patient's 4th diagnosis code, left justified;
(190) patient's 5th diagnosis code, left justified;
(191) patient's 6th diagnosis code, left justified;
(192) patient's 7th diagnosis code, left justified;
(193) patient's 8th diagnosis code, left justified;
(194) patient's 9th diagnosis code, left justified;
(195) patient's 10th diagnosis code, left justified;
(196) patient's 11th diagnosis code, left justified;
(197) patient's 12th diagnosis code, left justified;

(198) patient's 13th diagnosis code, left justified;
(199) patient's 14th diagnosis code, left justified;
(200) patient's 15th diagnosis code, left justified;
(201) patient's 16th diagnosis code, left justified;
(202) patient's 17th diagnosis code, left justified;
(203) patient's 18th diagnosis code, left justified;
(204) patient's admitting diagnosis code qualifier (9, 0, 1), left justified;
(205) patient's principal diagnosis code qualifier (9, 0, 1), left justified;
(206) patient's 2nd diagnosis code qualifier (9, 0, 1), left justified;
(207) patient's 3rd diagnosis code qualifier (9, 0, 1), left justified;
(208) patient's 4th diagnosis code qualifier (9, 0, 1), left justified;
(209) patient's 5th diagnosis code qualifier (9, 0, 1), left justified;
(210) patient's 6th diagnosis code qualifier (9, 0, 1), left justified;
(211) patient's 7th diagnosis code qualifier (9, 0, 1), left justified;
(212) patient's 8th diagnosis code qualifier (9, 0, 1), left justified;
(213) patient's 9th diagnosis code qualifier (9, 0, 1), left justified;
(214) patient's 10th diagnosis code qualifier (9, 0, 1), left justified;
(215) patient's 11th diagnosis code qualifier (9, 0, 1), left justified;
(216) patient's 12th diagnosis code qualifier (9, 0, 1), left justified;
(217) patient's 13th diagnosis code qualifier (9, 0, 1), left justified;
(218) patient's 14th diagnosis code qualifier (9, 0, 1), left justified;
(219) patient's 15th diagnosis code qualifier (9, 0, 1), left justified;
(220) patient's 16th diagnosis code qualifier (9, 0, 1), left justified;
(221) patient's 17th diagnosis code qualifier (9, 0, 1), left justified;
(222) patient's 18th diagnosis code qualifier (9, 0, 1), left justified;
(223) 1st e-code, left justified, (required);
(224) 2nd e-code, left justified;
(225) 3rd e-code, left justified;
(226) patient's admitting diagnosis, present on admission, left justified;
(227) patient's principal diagnosis, present on admission, left justified;
(228) patient's 2nd diagnosis, present on admission, left justified ;
(229) patient's 3rd diagnosis, present on admission, left justified ;
(230) patient's 4th diagnosis, present on admission, left justified ;
(231) patient's 5th diagnosis, present on admission, left justified ;
(232) patient's 6th diagnosis, present on admission, left justified ;
(233) patient's 7th diagnosis, present on admission, left justified ;
(234) patient's 8th diagnosis, present on admission, left justified ;
(235) patient's 9th diagnosis, present on admission, left justified ;
(236) patient's 10th diagnosis, present on admission, left justified ;
(237) patient's 11th diagnosis, present on admission, left justified ;
(238) patient's 12th diagnosis, present on admission, left justified ;
(239) patient's 13th diagnosis, present on admission, left justified ;
(240) patient's 14th diagnosis, present on admission, left justified ;
(241) patient's 15th diagnosis, present on admission, left justified ;
(242) patient's 16th diagnosis, present on admission, left justified ;
(243) patient's 17th diagnosis, present on admission, left justified ;
(244) patient's 18th diagnosis, present on admission, left justified ;
(245) patient's diagnosis related group (DRG) code ;
(246) patient's principal procedure code, left justified;
(247) patient's 2nd procedure code, left justified;
(248) patient's 3rd procedure code, left justified;
(249) patient's 4th procedure code, left justified;
(250) patient's 5th procedure code, left justified;
(251) patient's 6th procedure code, left justified;
(252) patient's 2nd procedure code, left justified;
(253) patient's 3rd procedure code, left justified;

(254) patient's 4th procedure code, left justified;
(255) patient's 5th procedure code, left justified;
(256) patient's 6th procedure code, left justified;
(257) patient's principal procedure code qualifier (9, 0, 1), left justified;
(258) patient's 2nd procedure code qualifier (9, 0, 1), left justified;
(259) patient's 3rd procedure code qualifier (9, 0, 1), left justified;
(260) patient's 4th procedure code qualifier (9, 0, 1), left justified;
(261) patient's 5th procedure code qualifier (9, 0, 1), left justified;
(262) patient's 6th procedure code qualifier (9, 0, 1), left justified;
(263) patient's 2nd procedure code qualifier (9, 0, 1), left justified;
(264) patient's 3rd procedure code qualifier (9, 0, 1), left justified;
(265) patient's 4th procedure code qualifier (9, 0, 1), left justified;
(266) patient's 5th procedure code qualifier (9, 0, 1), left justified;
(267) patient's 6th procedure code qualifier (9, 0, 1), left justified;

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 division and the human services department, pursuant to the reporting schedule contained in Subsection A of 7.1.27.10 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 division and the fiscal intermediary, pursuant to the reporting schedule contained in Subsection A of 7.1.27.9 NMAC.

F. **Annual financial statements:** All licensed non-federal general and specialty inpatient health care facilities shall submit annual audited financial statements to the division. 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 division. These reports shall be submitted no later than the end of the calendar year following the statement year.
[7.1.27.9 NMAC - N, 12/31/2012]

7.1.27.10 ELECTRONIC REPORTING REQUIREMENTS: Starting with 2012 data, all data providers shall submit the required quarterly discharge data pursuant to the reporting schedule contained in Subsection A of 7.1.27.9 NMAC and all final corrected reports, for the full year's worth of data, are due no later than March 31of the following year. Data providers shall submit data by electronic media, which includes CD, DVD, or direct electronic transmission by encrypted e-mail or secure file transmission protocol (SFTP), in an ASCII file format, per the most current record layout and instruction provided by the division. Data providers shall label all media and data files with the following information: type of data, hospital name and license number, year, file name, point of contact and telephone number, and mail data to "New Mexico department of health epidemiology and response division, attn: division, 1190 St. Francis Drive, Santa Fe, NM 87502." Any data transmitted by mail or overnight delivery is the responsibility of the data provider until it is acknowledged as received by the division. Therefore, all data transmitted by third party mail provider will be sent using a tracking mechanism (e.g., fedex tracking website) or be certified for acknowledgement (e.g., certified postal mail requiring a signature for delivery).
[7.1.27.10 NMAC - N, 12/31/2012]

7.1.27.11 REPORTING EXEMPTIONS: Upon written application to the division, the division may grant a health care facility a temporary exemption, not to exceed two reporting quarters, from the schedule required by Subsection A of 7.1.27.9 NMAC. Temporary exemption from reporting does not excuse the health care facility from reporting the requested data items for activity that occurred during the exempted period. Upon resumption of the regular reporting schedule the health care facility shall promptly report data for the exempted period.
[7.1.27.11 NMAC - N, 12/31/2012]

7.1.27.12 PENALTIES FOR REPORTING 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 HIS Act.
[7.1.27.12 NMAC - N, 12/31/2012]

7.1.27.13 GENERAL PROVISIONS ON ACCESS TO THE HEALTH INFORMATION SYSTEM DATA:

A. **Reporting:** In accordance with Subsections 24-14A-3 (D) (6), 24-14A-4.3 & 24-14A-6 (D) of the HIS Act, data may be reported routinely to authorized federal, state, and local public agencies. Record-level data shall be reported to the agency for healthcare research and quality (AHRQ) for incorporation into the healthcare cost and utilization project (HCUP) databases as part of the federal-state-industry partnership.

B. **Access requirements:** Data and reports based on the HIS may be obtained only in accordance with the requirements of the HIS Act and this rule. Any request for information that would not be contained in routine reports will require completion of a data request form available on the division's website or by contacting the division.

C. **Evaluation of requests:** In addition to other requirements stated in this rule, all requests for HIS data and reports, other than routine reports, shall be evaluated by the division and shall satisfy the following criteria for approval.

(1) The specific intended use of the data shall comport with the purposes of the HIS Act, as stated in 24-14A-3A and rules promulgated pursuant to the act, including use of data to assist in:

(a) the performance of health planning, policy making functions, and research conducted for the benefit of the public;

(b) informed health care decision making by consumers;

(c) surveillance for the control of disease and conditions of public health significance as required by Public Health Act, Subsection 24-1-3(C) NMSA 1978;

(d) administration, monitoring, and evaluation of a statewide health plan.

(2) The request shall be consistent with the responsibilities of the division in accomplishing the priorities of the HIS.

(3) The request is for data that are either:

(a) in a routine report previously published by the division, or

(b) aggregate data in or reports based on a subset or portion of the HIS database that is relevant to the individual's stated purpose upon approval of the request by the division , or

(c) record-level data, such that an individual patient or healthcare professional cannot be identified, pursuant to the HIS Act, to federal, state, and local public agencies, and upon approval of the request by the division.

D. **Request procedures:** All requests for data shall be made pursuant to the requirements of 7.1.27.14 NMAC.

E. **Fees:** Fees for access to data and reports shall be paid pursuant to the requirements of 7.1.27.18 NMAC.

F. **Restrictions on access to sensitive data:** The division shall have the authority to deny access to information from the HIS database where use of the information, as determined by the division, could result in violation of a patient's privacy.

G. **Compliance with other laws:** The division shall ensure that any access to data that is subject to restrictions on use pursuant to state, federal, or tribal law or regulation, or any other legal agreement, complies with those restrictions.

H. **Disclaimer:** The division shall include a disclaimer in all HIS data and reports released pursuant to this rule stating that the accuracy of the original data is the responsibility of the submitting data provider and that the division assumes no responsibility for any use made of or conclusions drawn from the data.

I. **Agency contractors:**

(1) A state or federal agency that receives HIS data or reports under an agreement with the division pursuant to 7.1.27.15 NMAC, 7.1.27.16 NMAC, and 7.1.27.17 NMAC shall be solely responsible for fulfillment of the agreement, including responsibility for the actions of any subcontractor engaged to perform services that require access to HIS data or reports.

(2) No state or federal agency shall subcontract any portion of services to be performed under an agreement with the division without prior written approval of the division.

(3) A state or federal agency subcontractor that is provided access to HIS data or reports shall be subject to the full provisions of the HIS Act, and this rule, including 7.1.27.15 NMAC, 7.1.27.16 NMAC, and 7.1.27.17.

J. **Public data:** The restrictions that apply to the release of data do not apply when the data provider is a government agency and the data provided to the HIS otherwise would be considered public data in accordance

with the Public Records Act, Sections 14-3-1 to 14-3-23, NMSA 1978, and the Open Meetings Act, Sections 10-15-1 to 10-15-4, NMSA 1978.

K. **Proprietary and confidential information:**

(1) Proprietary information and patient confidential information shall not be routinely disclosed in or as part of a public health information report by the division.

(2) A data provider that objects on proprietary grounds to the potential release in a public health information report, or a record level data disclosure, of its reported data or information derived from its reported data shall submit to the division a written request to exempt its data from such disclosures. By the end of each fiscal year (June 30th) data providers must notify, in writing, the division regarding data items that they deem proprietary. Application for an exemption must be addressed by a representative of the data provider to the division.

L. Final determination:

(1) The division shall prepare a recommended written decision in the format required by Subsection 39-3-1.1 NMSA 1978. The recommended written decision shall be approved or disapproved by the department division director or designee within 10 days or as expeditiously as possible after the issuance of the division's written recommendation.

(2) The decision by the department division director or designee is subject to review by the secretary at the secretary's discretion and is the final determination for purpose of judicial review.

(3) The department shall issue a final decision that includes an order granting or denying relief. The final decision may incorporate the division's recommended decision or the department may render any other final decision supported by law. The final decision shall include a statement of the factual and legal basis for the decision. [7.1.27.13 NMAC - N, 12/31/2012]

7.1.27.14 PROCEDURES FOR REQUESTS OF THE HIS DATA:

A. **Requests for public and previously-prepared routine reports:** Requests for copies of public and routine reports produced by the division for public use shall be made either in writing or by e-mail to the division. Fees for these reports shall be paid in accordance with 7.1.27.18 NMAC.

B. **Requests for previously-prepared, non-routine reports:** Requests for copies of previously-prepared, non-routine reports shall be made in writing or by e-mail to the division. These reports shall be made available pursuant to the requirements of this rule. Fees for these reports shall be paid in accordance with 7.1.27.18 NMAC.

C. **Individualized requests:** Requests for not previously prepared, non-routine reports, or for data contained in the HIS database shall be made in writing to the division by specifying the following information on a request form provided by the division.

(1) Date of request.

(2) Name, address, and organizational affiliation.

(3) Specific data or analysis requested.

(4) Specific intended use of the data, including proposed analytical or research methodology, and expected outcomes of analysis, together with an acknowledgment that the data will not be used in violation of 7.1.27.19 NMAC and 7.1.27.20 NMAC.

(5) Desired date by which the information is needed, allowing a minimum of two weeks to process the request.

(6) For requests for data, the names and positions of individuals who will have access to the data if the request is granted.

(7) For requests for data, the requestor's specific plans for protecting these data and use of the data in accordance with the requirements of the HIS Act, and this rule.

(8) Any additional information the division may request.

D. **Review of requests for data:** The division shall conduct a preliminary review of requests made for HIS data or reports and may require the requestor to submit supplemental information to achieve a final project request. As required by this rule, the division will make the determination on whether to grant the request. Requestors shall be notified of whether the request meets the criteria for approval within a reasonable period of time from the initial date of the request. The division shall make reasonable efforts to review requests expeditiously within available resources.

E. **Provision of data:** The division shall prepare data or reports for approved requests within a reasonable period of time given the nature of the request, making reasonable efforts to prepare the information expeditiously within available resources.

F. **Fee estimate:** If a request for data or reports made pursuant to 7.1.27.14 NMAC is approved, the division shall prepare a preliminary estimate of the fee required for preparing the data or report, in accordance with 7.1.27.18 NMAC. This estimate, which shall not serve as a guarantee of final charges, shall be included with the notification of approval or disapproval provided pursuant to Subsection D of 7.1.27.14 NMAC. If the requestor agrees to pay the fee, the division shall proceed with preparing the data or report.
[7.1.27.14 NMAC - N, 12/31/2012]

7.1.27.15 ACCESS TO ROUTINE AND PUBLISHED REPORTS: The division shall release reports to the public on a periodic schedule as determined by the division and in accordance with the HIS Act.
[7.1.27.15 NMAC - N, 12/31/2012]

7.1.27.16 ACCESS TO AGGREGATE DATA AND REPORTS: Individuals: Pursuant to the requirements of 7.1.27.13 NMAC, any person may obtain access to aggregate data in or reports based on the subset or portion of the HIS database that is relevant to the individual's stated purpose upon approval of the request by the division.
[7.1.27.16 NMAC - N, 12/31/2012]

7.1.27.17 ACCESS TO DE-IDENTIFIED RECORD-LEVEL DATA:

A. **Disclosure authorization:** Pursuant to the requirements of the HIS Act and 45 CFR 164.512, New Mexico state agencies or political subdivisions, and federal agencies authorized to collect, analyze. or disseminate health information, may obtain access to record level data in or records based upon the subset or portion of the record level data that is relevant to the organization's or agency's stated purpose, upon approval of the request by the director. The director may require such agency or organization to agree to specific confidentiality and data use requirements prior to the release of the data or reports. Federal agencies may obtain the information only if the agency agrees to fully protect its confidentiality as provided by state and federal law. No other persons or entities shall have access to data in, or non-aggregate analytical reports based on the record level data.

B. **Protection of identity:** Any data or report that is provided from the HIS database shall be configured in a manner that precludes actual or potential identification of individual patients, as defined in 45 CFR Subsection 164.514(e), or health care providers unless the division determines that disclosure of identifiable hospital information is necessary for a state, tribal, or federal agency's or local political subdivision's authorized use, and that the disclosure complies with state and federal privacy and confidentiality laws, rules, and regulations.

C. Deletion of data: The requestor shall delete the HIS data file upon completion of the approved research and shall not retain any copies of HIS data files. The requestor must inform the division annually of the status of the work being done, the expected date of HIS dataset deletion, description of how HIS data files are stored, and a cumulative listing of how the HIS dataset has been used as well as any publications or presentations that were informed or created using the HIS data file (unless otherwise agreed to in writing).
[7.1.27.17 NMAC - N, 12/31/2012]

7.1.27.18 FEES FOR DATA AND REPORTS:

A. **Fees for routine reports:**

(1) **Generally:** The fees for copies of available routine reports produced for public use shall be as follows:

(a) single copies of any consumer health information reports or HIS annual reports shall be provided free of charge upon request; and

(b) all other reports shall be provided for $10.00 per report.

(2) **Data providers:** Data providers may receive one free copy of the division's routine reports upon request.

B. **Previously-prepared reports:** The fee for copies of available previously-prepared, non-routine reports provided to persons other than the original requestor for whom the report was prepared shall be $20.00 per report.

C. **Fees for data and non-routine reports:** The fee for preparing data and non-routine reports that have not been previously prepared shall be charged at the hourly rate of the analyst(s) preparing the data or report, as follows:

(1) data providers shall be charged a rate of $50.00 per analyst hour;
(2) state agencies shall be charged a rate of $75.00 per analyst hour; and
(3) all others shall be charged a rate of $100.00 per analyst hour.

D. **Electronic media reports:** Fees for reports made available on electronic media may include charges for the cost of the magnetic tape, diskette, CD-ROM, or other electronic media, in addition to the fees required by this section.

E. **Waiver or reduction of fees:**

(1) **Standard for waiver or reduction:** The division may reduce or waive the fee for routine reports, data, and non-routine reports that have not been previously prepared when the division determines that the requestor's proposed use of the information would be of value to the division in fulfilling its statutory mandates to a degree equal to or greater than the fee reduction or waiver.

(2) **Payment upon failure to perform:** When a fee waiver or reduction has been granted and the research for which the fee was waived or reduced is not completed, or the product for which the fee was waived or reduced is not delivered to the division, the full fee shall be assessed in accordance with Subsection C of 7.1.27.18 NMAC.

F. **Statement of fees:** The division shall prepare a statement of the fee for requests made pursuant to Subsection C of 7.1.27.14 NMAC and provide it to the requestor with the data or report. The fee must be paid no later than 30 days after receipt of the data or report.

[7.1.27.18 NMAC - N, 12/31/2012]

7.1.27.19 OBLIGATIONS UPON RECEIPT OF DATA:

A. **Specific requirements:** Requestors and any individuals who are permitted access to HIS data or reports through approval of a request made pursuant to Subsection C of 7.1.27.14 NMAC shall.

(1) Limit use of the information to the purposes stated on the request form.

(2) Give full credit to the division in any published or unpublished reports using HIS information unless otherwise agreed to in writing.

(3) Include a disclaimer in any published or unpublished reports using HIS information which states that the accuracy of the original data is the responsibility of the submitting data provider and that the division assumes no responsibility for any use made of or conclusions drawn from the data unless otherwise agreed to in writing.

(4) Provide the division with a copy of any reports, papers, posters or other publication (electronic or otherwise) resulting from access to the HIS database unless otherwise agreed to in writing.

B. **Prior approval:** The division shall review and approve in advance of distribution any report or analysis produced using data from the HIS database to any person beyond those specified in the request made pursuant to Subsection C of 7.1.27.14 NMAC unless otherwise agreed to in writing. Reports or analysis of this nature shall not be released if disapproved by the division.

[7.1.27.19 NMAC - N, 12/31/2012]

7.1.27.20 REDISCLOSURE OF DATA: Requestors who are permitted access to aggregate data from non-routine reports, as well as record-level data, (as described in 7.1.27.16 NMAC and 7.1.27.17 NMAC of this rule) shall not (unless otherwise agreed to in writing):

A. provide the data or portion of it to any persons other than those identified in the request form; or

B. share, release, or otherwise give any or all of the information contained in the HIS dataset to any person or institution not listed on the data request form; or

C. resell any portion of the data or other information gained as a result of obtaining access to the data.

[7.1.27.20 NMAC - N, 12/31/2012]

7.1.27.21 REPORTS AVAILABLE THROUGH THE STATE LIBRARY DEPOSITORY SYSTEM: Paper copies of all public use routine reports produced by the division shall be available to the public through the state library depository system.

[7.1.27.21 NMAC - N, 12/31/2012]

7.1.27.22 PENALTIES FOR RULE VIOLATION:

A. **Division sanctions:** A requestor who violates the requirements of this rule may be subject to any or all of the following sanctions, as determined by the division.

(1) Temporary or permanent denial of access to HIS data or reports.

(2) Termination of current access.

(3) Mandated immediate return, without duplication, of HIS data or reports provided by the division.

B. **Other penalties:** A requestor who violates the requirements of this rule or the HIS Act, may be subject to sanctions provided in applicable state, federal, or tribal laws or regulations, including but not limited to injunctive relief and civil penalties of up to $1,000 per violation.
[7.1.27.22 NMAC - N, 12/31/2012]

HISTORY OF 7.1.27 NMAC: [RESERVED]