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 NMAC 1.1.1, 03/31/2008]

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 - Rp, 7 NMAC 1.1.2, 03/31/2008]

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 NMAC 1.1.3, 03/31/2008]

7.1.4.4 DURATION: Permanent.
[7.1.4.4 NMAC - Rp, 7 NMAC 1.1.4, 03/31/2008]

7.1.4.5 EFFECTIVE DATE: March 31, 2008, unless a later date is cited at the end of a section.
[7.1.4.5 NMAC - Rp, 7 NMAC 1.1.5, 03/31/2008]

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 NMAC 1.1.6, 03/31/2008]

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. **Age of patient** means the age of the patient at discharge calculated from the patient birth date.

(1) For patients one year and over, the age is stated in years, e.g., 1, 2, 3, etc.

(2) For patients under one year, the age of the patient is stated in days for the first month and in months thereafter.

(3) For newborns, the age is stated as follows:

Age	Code used
newborn	OD (zeroD)
1 day-31 days	1 D, 2D, ... 31 D
1 month -11 months	1 m, 2 m, ... 11 m

B. **Attending physician** code means the six digit unique physician identification number, assigned by medicare, of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered or who has primary responsibility for the patient's medical care and treatment.

C. **Calendar quarter ending** means the ending month, day, and year of the calendar quarter for which the data are reported. Report as "MMDDYYYY" (month day year), e.g. "09171990".

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. **E-code** means the ICD-9-CM diagnosis code for external causes of injury, poisoning, or adverse effect.

G. **EMS ambulance run number** means the emergency medical services ambulance run number.

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

I. **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.

J. **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.

K. **Length of stay** means the number of patient days.

(1) **Calculation:** Calculate length of stay by using the admission and discharge dates of patient in conjunction with the following New Mexico hospital association definition: "A patient day is the unit of measure denoting lodging provided and services rendered to patients between the census taking hours (usually at midnight) of two successive days. A patient formally admitted who is discharged or dies on the same day is counted as one patient day, regardless of the number of hours the patient occupies a hospital bed."

(2) **Coding:** Code length of stay as digits, for example: 1, 2, 3, ... etc.

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

M. **National Provider Identifier (NPI)** means the ten digit NPI from the national plan and provider enumeration system (NPPES).

N. **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).

O. **Operating physician code** means the six digit unique physician identification number, assigned by medicare, of the licensed physician providing the principal surgical procedure.

P. **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.

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

R. **Patient 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.

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

U. **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.

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

W. **Patient DRG code** means the diagnostic related group code.

X. **Patient ethnicity/race** means the gross classification of patient's stated ethnicity, coded as follows:

(1) A - Asian/Pacific Islander;
(2) B - black;
(3) H - Hispanic;
(4) I - Native American Indian;
(5) O - other;
(6) U - unknown;
(7) W- white.

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

Z. **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.

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

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

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

DD. **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** mean 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.

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

FF. **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".

GG. **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 - 29 - reserved for national assignment;
(13) 30 - still patient or expected to return for outpatient services;
(14) 31 - 39 - reserved for national assignment;
(15) 40 - expired at home (hospice claims only);
(16) 41 - expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (hospice claims only);
(17) 42 - expired - place unknown (hospice claims only);
(18) 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);
(19) 44 - 49 - reserved for national assignment;
(20) 50 - discharged/transferred to hospice - home;
(21) 51 - discharged/transferred to hospice - medical facility;
(22) 52 - 60 - reserved for national assignment;
(23) 61 - discharged/transferred within this institution to a hospital based medicare approved swing bed;
(24) 62 - discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital;
(25) 63 - discharged/transferred to long term care hospitals;
(26) 64 - discharged/transferred to a nursing facility certified under medicaid but not certified under medicare;
(27) 65 - discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital;
(28) 66 - discharged/transferred to a critical access hospital (CAH) (effective 03/31/2008);
(29) 67 - 69 reserved for national assignment;
(30) 70 - discharge/transfer to another type of health care institution not defined elsewhere in the code list (effective 03/31/2008);
(31) 71-99 - reserved for national assignment.

HH. **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**.

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

JJ. **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.**

KK. **Principal diagnosis code** means the full four or five digit ICD-9-CM code describing the principal diagnosis of the patient at discharge.

LL. **Principal procedure code** means the full three or four digit ICD-9-CM code that identifies the principal procedure performed that is most related to the principal diagnosis or the one which was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes.

MM. **Principal procedure date** means the date the principal procedure reported as the principal procedure code was performed.

NN. **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.

OO. **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**.

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

QQ. **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**.

RR. **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.

SS. **Source of admission** means an inpatient only code indicating the source of this admission.

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

(a) 1--physician referral - 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;

(b) 2--clinic referral - the patient was admitted to this facility upon recommendation of this facility's clinic physician;

(c) 3--HMO referral - the patient was admitted to this facility upon the recommendation of a health maintenance organization physician;

(d) 4--transfer from hospital - the patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient;

(e) 5--transfer from skilled nursing facility - the patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was an inpatient;

(f) 6--transfer from another health care facility - the patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or skilled nursing facility;

(g) 7--emergency room - the patient was admitted to this facility upon the recommendation of this facility's emergency room physician;

(h) 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;

(i) 9--information not available - the source of admission is unknown.

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

(a) 1--normal birth - a baby delivered without complications;

(b) 2--premature birth - a baby delivered with time or weight factors qualifying it for premature status;

(c) 3--sick baby - a baby delivered with medical complications, other than those relating to premature status;

(d) 4--extramural - A newborn birth in a non-sterile birth environment.

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

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

VV. **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.

WW. **Zip code of patient's residence** means the zip code of patient's residence at the time of discharge. Use either five or nine digits, e.g. 87501 or 875010968. If unknown, leave blank. Do not use the zip code of the data source providing the reported service(s).
[7.1.4.7 NMAC - Rp, 7 NMAC 1.1.7, 03/31/2008]

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 NMAC 1.1.9, 03/31/2008]

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 1998 (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 commission
January 1 - March 31	June 30
April 1 - June 30	September 30
July 1 - September 30	December 31
October 1 - December 31	March 31 of the following year

B. **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) attending physician code; or national provider identifier (NPI); after July 1, 2008, NPI only;
(2) calendar quarter ending;
(3) e-code, if the facility systematically collects the data in the ordinary course of operations as part of the facility's standard operating procedures;
(4) length of stay;
(5) medicare provider number;
(6) New Mexico state license number;
(7) operating physician code; or national provider identifier (NPI); after July 1, 2008 NPI only;
(8) patient address;
(9) patient admission date;
(10) patient control number;
(11) patient date of birth;
(12) patient diagnosis related group (DRG) code;
(13) patient 2nd diagnosis code;
(14) patient 3rd diagnosis code;
(15) patient 4th diagnosis code;
(16) patient 5th diagnosis code;
(17) patient 6th diagnosis code;
(18) patient 7th diagnosis code;
(19) patient 8th diagnosis code;
(20) patient 9th diagnosis code;
(21) patient discharge date;
(22) patient emergency medical services ambulance run, if the facility systematically collects the data in the ordinary course of operations as part of the facility's standard operating procedures;
(23) patient ethnicity/race, if the facility systematically collects the data in the ordinary course of operations as part of the facility's standard operating procedures;
(24) patient first name (do not report if medicaid is anticipated primary or secondary payer, leave data field blank);
(25) patient last name (do not report if medicaid is anticipated primary or secondary payer, leave data field blank);

(26) patient medicaid I.D. number (report only if medicaid is anticipated primary or secondary payer; otherwise do not report, leave data field blank);

(27) patient medical record number;

(28) patient middle initial (do not report if medicaid is anticipated primary or secondary payer, leave data field blank);

(29) patient New Mexico traffic crash report number, if the facility systematically collects the data in the ordinary course of operations as part of the facility's standard operating procedures;

(30) patient 2nd procedure code;

(31) patient 3rd procedure code;

(32) patient 4th procedure code;

(33) patient 5th procedure code;

(34) patient 6th procedure code;

(35) patient social security number (do not report if medicaid is anticipated primary or secondary payer, leave data field blank);

(36) patient status;

(37) primary payer category;

(38) primary payer identification name;

(39) primary payer type;

(40) principal diagnosis code;

(41) principal procedure code;

(42) principal procedure date;

(43) provider zip code;

(44) secondary payer category;

(45) secondary payer identification name;

(46) secondary payer type;

(47) sex of patient;

(48) source of admission;

(49) total charges;

(50) type of admission;

(51) zip code of patient's residence.

C. **Data reporting requirements when medicaid is payer:** If medicaid is the anticipated primary or secondary payer, report all elements pursuant to Subsection B of 7.1.4.10 NMAC including the patient medicaid I.D. number, but do not report:

(1) patient first name;

(2) patient middle initial;

(3) patient last name; or

(4) patient social security number.

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 blue cross blue shield of New Mexico or any successor 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. 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 NMAC 1.1.10, 03/31/2008]

7.1.4.11 ELECTRONIC REPORTING REQUIREMENTS: As of January 1, 1999, all data providers shall submit the required quarterly discharge data by electronic media (includes computer tape, cartridge or diskette) or by direct electronic transmission, per the record layout and instruction provided by the commission.

[7.1.4.11 NMAC - Rp, 7 NMAC 1.1.11, 03/31/2008]

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 NMAC 1.1.12, 03/31/2008]

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 NMAC 1.1.13, 03/31/2008]

HISTORY OF 7.1.1 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.

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.