Rules of
Department of Health and Senior Services
Division 10—Office of the Director
Chapter 33—Hospital and Ambulatory Surgical Center Data Disclosure

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES

Division 10—Office of the Director

Chapter 33—Hospital and Ambulatory Surgical Center Data Disclosure

19 CSR 10-33.010 Reporting Patient Abstract Data by Hospitals and Ambulatory Surgical Centers

PURPOSE: This rule establishes procedures for reporting patient abstract data for inpatients and outpatients by hospitals and ambulatory surgical centers to the Department of Health and Senior Services and for the management and dissemination of this data.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) The following definitions shall be used in the interpretation of this rule:

(A) Coinvestigator means any person or organization that applies to the Department of Health and Senior Services to be a coinvestigator of an epidemiological study;

(B) Department means the Missouri Department of Health and Senior Services;

(C) Epidemiological study means research using patient abstract data to understand, promote, or safeguard the health of a defined population. No marketing study or study designed to use data on a specific provider shall be considered an epidemiological study;

(D) Inpatient encounter means an encounter which begins with the formal acceptance by a hospital or a distinct part of a hospital of a patient who is to receive physician, dentist, or allied services while receiving room, board, and continuous nursing care. It ends with the termination of the room, board, and continuous nursing services, and the formal release of an inpatient from the hospital or the transfer of the patient to a different distinct hospital unit. All significant procedures are to be reported. A significant procedure is one that is surgical in nature; carries a procedural risk; requires specialized training; carries an anesthetic risk such as open procedures, endoscopy procedures, catherization procedures, pain management procedures, injection procedures such as myelograms, arthrograms, etc.; or is needed for Medicare Severity Diagnosis Related Group (MS-DRG) assignment. Inpatient procedures should be coded according to the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS);

(E) Observation services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Charges for observation services usually are made on an hourly basis. Observation services usually do not exceed twenty-four (24) hours. However, there is no hourly limit on the extent to which they may be used;

(F) Outpatient encounter refers to patients seen in the emergency room and patients receiving invasive procedures on an outpatient basis. All significant procedures are to be reported. A significant procedure is one that is surgical in nature; carries a procedural risk; requires specialized training; or carries an anesthetic risk such as open procedures, endoscopy procedures, catherization procedures, pain management procedures, injection procedures such as myelograms, arthrograms, etc. Outpatient procedures should be coded according to the Healthcare Common Procedure Coding System (HCPCS). HCPCS is divided into two (2) principal subsystems, referred to as level I and level II. Level I is comprised of Current Procedural Terminology (CPT-4), and level II is a standardized coding system used to report services not identified by CPT-4 codes;

(G) Public health authority means an agency or authority that is responsible for public health matters as part of its official mandate. Examples of public health authorities include agencies of a state, territory, political subdivision of a state or territory, or an Indian tribe, or persons or entities acting under a grant of authority or contract with a public health authority.

(2) Data which meet the completeness, validity, and consistency criteria in subsections (2)(C) and (D) of this rule shall be submitted to the department or to an association or related organization with which the department has a binding agreement to obtain data on a quarterly basis according to the Data Reporting Schedule in Table 1, included herein. Data shall be considered to be submitted when received by the department or the association or related organization prior to the close of business on the scheduled due date. Requests for extensions shall be submitted to the department at least ten (10) working days prior to the due date as listed in Table 1. Extensions to the submittal schedule may be granted for a maximum of thirty (30) calendar days. The facility shall separately request each additional thirty (30) calendar day extension.

Table 1 – Data Reporting Schedule

Quarter	Period of Patient Encounter (Discharge Date)	Date Due
1st	January 1 – March 31	June 1
2nd	April 1 – June 30	September 1
3rd	July 1 – September 30	December 1
4th	October 1 – December 31	March 1 of the following year

(A) Each facility shall submit to the department, or to an association or related organization with which the department has a binding agreement to obtain data, a single record for each patient discharge, according to the schedule shown in Table 1 – Data Reporting Schedule, included herein. For a patient with multiple discharges, a facility shall submit a separate data record for each individual discharge. For a patient with multiple billing claims, a facility shall consolidate the multiple billings into a single discharge data record for submission after the patient's discharge.

(B) The patient abstract data shall include the data elements and conform to the specifications listed in the document entitled "Patient Abstract System File Specifications" dated October 27, 2014, which is incorporated by reference in this rule and is available at the Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570 or on the department's website at http://health.mo.gov/data/pdf/paslayout.pdf, for all records with a discharge date of October 1, 2015 or later. This rule does not incorporate any subsequent amendments or additions. The patient abstract data shall be submitted electronically through the department's online system or by any other mutually agreed upon method. The Department of Health and Senior Services, Bureau of Health Care Analysis and Data Dissemination may be contacted by mail at PO Box 570, Jefferson City, MO 65102-0570 or by telephone at (573) 751-6272.

(C) Each data element shall have an acceptable code in at least ninety-nine percent (99%) of the records. Each data element shall be missing or unknown in less than one percent (1%) of records.

(D) The following data elements shall be consistent within at least ninety-nine percent (99%) of individual records:

1. Date of birth, sex, diagnoses, External Cause of Morbidity (ECM) code, Present On Admission (POA) ECM code, ECM Place of Occurrence code, ECM Activity code, ECM Status code, procedure(s);

2. State of residence, zip code, county; and

3. Admission date, procedure date(s), discharge date, date of birth.

(3) After the due date listed in Table 1, included herein, providers shall be allowed fifteen (15) working days from the date of notification by the department to correct identified data submission errors. Revisions of data originally filed shall contain the entire quarterly dataset.

(4) Providers may submit the required data to the department through an association or related organization with which the department has a binding agreement to obtain data. The association or related organization shall provide to the department by January 1 of each year a list of providers for whom it will submit data. Providers selecting this option are responsible for ensuring that the data meet the quality criteria of completeness, validity, and consistency in subsections (2)(C) and (D) of this rule. Data shall be submitted to the association or related organization according to the time schedule in section (2), Table 1, included herein, of this rule. The association or related organization is responsible for ensuring that the data are provided to the department using one (1) of the submission methods specified in subsection (2)(B) of this rule and conform to the specifications listed in the document entitled "Patient Abstract System File Specifications" dated October 27, 2014, which is incorporated by reference in this rule and is available at the Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570 or on the department's website at http://health.mo.gov/data/pdf/paslayout.pdf, for all records with a discharge date of October 1, 2015 or later. This rule does not incorporate any subsequent amendments or additions. The association shall submit provider data to the department within thirty (30) days following the due date listed in section (2), Table 1, included herein, of this rule. The association or related organization may submit a request for extension, as described in section (2) of this rule, on behalf of a facility.

(5) Providers may submit data directly to the department or through a third party acting as their agent, other than one (1) with which the department has a binding agreement. Providers selecting this option shall be responsible for ensuring that all data specifications conform to the requirements listed in section (2) of this rule. The third party agent may submit a request for extension, as described in section (2) of this rule, on behalf of a facility.

(6) The department may develop and publish reports pertaining to individual hospitals and ambulatory surgical centers. The reports may include information on charges and quality of care indicators. The reports and the data they contain shall be public information and may be released on electronic media. The department shall make the reports and data available for a reasonable charge based on incurred costs.

(7) The department shall use statistical rules to minimize random fluctuations and extreme outliers in publishing provider-specific reports on charges. The rules may vary by publication but average charges based on fewer than twenty (20) events shall not be published.

(8) The department may develop summary reports upon request which do not directly or indirectly identify patients, physicians, or providers. The reports shall be public information. The department shall make the reports available for a reasonable charge based upon incurred costs.

(9) The department shall store the patient abstract data in password-protected directories to limit access of the data only to employees of the department who are designated to have access to the files.

(10) The department may release patient abstract data to a public health authority to assist the agency in fulfilling its public health mission. Public health authorities shall follow the same guidelines used by the department when releasing summary reports based on record-level data. Record-level data shall not be rereleased in any form by the public health authority without the prior authorization of the department. Authorization for subsequent release of the data shall be considered only if the proposed release does not identify a patient, physician, or provider. The following data elements permit identification of a patient, physician, or provider, and shall not be rereleased by a public health authority: patient name; patient Social Security number; any datum which applies to fewer than three (3) patients, physicians, or providers; physician number; provider number; and a quantity figure if one (1) hospital or ambulatory surgical center contributes more than sixty percent (60%) of the amount. However, the department may authorize contact with the patient, physician, or provider based upon the information supplied. The physician and provider that provided care to a patient shall be informed by the public health authority of any proposed contact with a patient.

(11) The public health authority shall agree to the department's requirements regarding the confidentiality, security, and release of data and shall agree to the review and oversight requirements imposed by the department.

(12) Any person may apply to the department to be a coinvestigator of an epidemiological study using patient abstract data. A research protocol shall be submitted which includes all of the following:

(A) A description of the proposed study;

(B) The purpose of the study;

(C) A description of the data elements needed for the study;

(D) A statement indicating whether the study protocol has been reviewed and approved by an institutional review board;

(E) A description of data security procedures, including who shall have access to the data; and

(F) A description of the proposed use and release of the data.

(13) The director of the department shall appoint a data release advisory committee which may be composed of representatives from the department, the Hospital Industry Data Institute (HIDI) of the Missouri Hospital Association (MHA), and other entities. The advisory committee shall review all research protocols of persons applying to be a coinvestigator of an epidemiological study using patient abstract data. The advisory committee shall make a recommendation to the department whether the coinvestigator protocol should be accepted, accepted with conditions, or rejected. The committee shall consider the following factors:

(A) The review made by the staff of the department;

(B) Whether the proposed study meets the definition of an epidemiological study;

(C) The potential for the coinvestigator or any other person to use the data for nonepidemiological purposes;

(D) The professional expertise of the applicant to conduct the study;

(E) The appropriateness of the proposed study design;

(F) The willingness and ability of the applicant to protect the identity of any patient, physician, or provider;

(G) The data security measures and final disposition of the data proposed; and

(H) Whether the proposed study is relevant to public health in Missouri.

(14) The coinvestigator shall follow the same guidelines used by the department when releasing summary reports based on record-level data. Record-level data released to the coinvestigator shall not be rereleased in any

form by the coinvestigator without the prior authorization of the department. Authorization for subsequent release of record-level data or summary reports shall be considered only if the proposed release does not identify a patient, physician, or provider. The following data elements permit identification of a patient, physician, or provider, and are not to be rereleased by a coinvestigator: patient name; patient Social Security number; any datum which applies to fewer than three (3) patients, physicians, or providers; physician number; provider number; and a quantity figure if one (1) hospital or ambulatory surgical center contributes more than sixty percent (60%) of the amount.

(15) The coinvestigator shall agree to the department's requirements regarding the confidentiality, security, and release of data and shall agree to the review and oversight requirements imposed by the department.

(16) The department shall release only those patient abstract data elements to the coinvestigator which the department determines are essential to the study. The National Provider Identifier (NPI) associated with any patient abstract data shall not be released to any coinvestigator. If the research being conducted by a coinvestigator requires a physician number, the department may create a unique number which is not the NPI. The department shall not provide information which links the unique number to the name of the physician.

(17) No epidemiological study conducted with a coinvestigator shall be approved unless the department determines that—

(A) The epidemiological study has public benefit sufficient to warrant the department to expend resources necessary to oversee the project with the coinvestigator;

(B) The department has sufficient resources available to oversee the project with the coinvestigator; and

(C) The data release advisory committee reviewed the study and the director of the department authorized approval.

(18) Public health authorities and coinvestigators receiving data shall be informed by the department of the penalty for violating section 192.067, RSMo.

(19) Any provider which determines that it will be temporarily unable to comply with any of the provisions of sections (1) through (5) of this rule or with the provisions of a previously-submitted plan of correction shall provide the department with written notification of the expected deficiencies and a written plan of correction. This notification and plan of correction shall include the specific reasons why the provider cannot comply with the rule, an explanation of any extenuating factors which may be relevant, the means the provider will employ for correcting the expected deficiency, and the date by which each corrective measure will be completed.

(20) Any provider which is not in compliance with sections (1) through (5) of this rule shall be notified in writing by the department. The notification shall specify the section number and text of the rule in question, the deficiency, and the action which must be taken to be in compliance. The chief executive officer or designee shall have ten (10) working days following receipt of the written notification of noncompliance to provide the department with a written plan for correcting the deficiency. The plan of correction shall specify the means the provider will employ for correcting the cited deficiency and the date that each corrective measure will be completed.

(21) Upon receipt of a required plan of correction, the department shall review the plan to determine the appropriateness of the corrective action. If the plan is acceptable, the department shall notify the chief executive officer or designee in writing and indicate that implementation of the plan should proceed. If the plan is not acceptable, the department shall notify the chief executive officer or designee in writing and indicate the reasons why the plan was not accepted. A revised, acceptable plan of correction shall be provided to the department within ten (10) working days.

(22) Failure of the provider to submit an acceptable plan of correction within the required time shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the director of the department.

(23) Failure of any provider to follow its accepted plan of correction shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the director of the department.

(24) Any provider in continued and substantial noncompliance with this rule shall be notified in writing and reported by the department to its appropriate licensing program within the Division of Regulation and Licensure and the Bureau of Special Health Care Needs, the MO HealthNet Division of the Department of Social Services, and other state agencies that administer a program with provider participation. The department shall notify the agencies that the provider is no longer eligible for participation in a state program or to receive any monies from the state.

(25) Any provider that has been declared to be ineligible to participate in a state program or to receive any monies from the state shall be eligible for reinstatement by correcting the deficiencies and making written application for reinstatement to the Department of Health and Senior Services. Any provider meeting the requirements for reinstatement shall be notified in writing. Those agencies that received a notice pursuant to section (24) of this rule shall be notified by the Department of Health and Senior Services when the provider has come into compliance.

AUTHORITY: section 192.667, RSMo Supp. 2013. Emergency rule filed Nov. 4, 1992, effective Nov. 14, 1992, expired March 13, 1993. Emergency rule filed March 4, 1993, effective March 14, 1993, expired July 11, 1993. Original rule filed Nov. 4, 1992, effective June 7, 1993. Emergency amendment filed April 1, 1993, effective April 11, 1993, expired Aug. 8, 1993. Emergency amendment filed Aug. 10, 1993, effective Aug. 20, 1993, expired Nov. 18, 1993. Amended: Filed April 1, 1993, effective Dec. 9, 1993. Amended: Filed May 15, 1998, effective Nov. 30, 1998. Emergency amendment filed March 1, 2001, effective April 1, 2001, expired Jan. 10, 2002. Amended: Filed April 13, 2001, effective Oct. 30, 2001. Rescinded and readopted: Filed Jan. 29, 2015, effective Sept. 30, 2015.*

**Original authority: 192.667, RSMo 1992, amended 1993, 1995.*

19 CSR 10-33.020 Reporting Charges for Leading Diagnoses and Procedures by Hospitals and Ambulatory Surgical Centers

PURPOSE: This rule establishes procedures for reporting charges for leading diagnoses and procedures by hospitals and ambulatory surgical centers to the Department of Health.

(1) Hospitals and ambulatory surgical centers shall report to the Department of Health by March 1 of each year, the charges as of December 31 of the previous year for the diagnoses and procedures listed in Exhibit C of this rule, included herein.

(2) The Department of Health may develop and publish reports pertaining to individual providers. The reports and the data they contain shall be public information and may be

released on magnetic media. The Department of Health shall make the reports and data available for a reasonable charge based upon incurred costs.

(3) The Department of Health may develop reports and release data upon request which do not directly or indirectly identify individual providers. The reports and data shall be public information and may be released on magnetic media. The Department of Health shall make the reports and data available for a reasonable charge based upon incurred costs.

(4) Any provider which determines it temporarily will be unable to comply with any part of this rule or with the provisions of a previously submitted plan of correction can provide the Department of Health with written notification of the expected deficiencies and a written plan of correction. The notification and plan of correction shall include the section number and text of the rule in question, specific reasons why the provider cannot comply with the rule, an explanation of any extenuating factors which may be relevant, the means the provider will employ for correcting the expected deficiency, and the date by which each corrective measure will be completed.

(5) Any provider which is not in compliance with this rule shall be notified in writing by the Department of Health. The notification shall specify the deficiency and the action which must be taken to be in compliance. The chief executive officer or designee shall have ten (10) working days following receipt of the written notification of noncompliance to provide the Department of Health with a written plan for correcting the deficiency. The plan of correction shall specify the means the provider will employ for correcting the cited deficiency and the date that each corrective measure will be completed.

(6) Upon receipt of a required plan of correction, the Department of Health shall review the plan to determine the appropriateness of the corrective action. If the plan is acceptable, the Department of Health shall notify the chief executive officer or designee in writing and indicate that implementation of the plan should proceed. If the plan is not acceptable, the Department of Health shall notify the chief executive officer or designee in writing and indicate the reasons why the plan was not accepted. A revised, acceptable plan of correction shall be provided to the Department of Health within ten (10) working days.

(7) Failure of the provider to submit an acceptable plan of correction within the required time shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the director of the Department of Health.

(8) Failure of any provider to follow its accepted plan of correction shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the director of the Department of Health.

(9) Any provider in continued and substantial noncompliance with this rule shall be notified by registered mail and reported by the Department of Health to its Bureau of Hospital Licensing and Certification, Bureau of Narcotics and Dangerous Drugs, Bureau of Emergency Medical Services, Bureau of Home Health Licensing and Certification, Bureau of Radiological Health, State Public Health Laboratory, Bureau of Special Health Care Needs, the Division of Medical Services of the Department of Social Services, the Division of Vocational Rehabilitation of the Department of Elementary and Secondary Education and to other state agencies that administer a program with provider participation. The Department of Health shall notify the agencies that the provider is no longer eligible for participation in a state program.

(10) Any provider that has been declared to be ineligible for participation in a state program shall be eligible for reinstatement by correcting the deficiencies and making written application for reinstatement to the Department of Health. Any provider meeting the requirements for reinstatement shall be notified by registered mail. The Department of Health shall notify state agencies that administer a program with provider participation that the provider's eligibility for participation in a state program has been reinstated.

EXHIBIT C

List of Diagnoses and Procedures List of Inpatient Diagnoses

Cesarean section without complications or comorbidities, or both
Four-day stay
DRG 371

Vaginal delivery without complicating diagnoses
Two-day stay
DRG 373

Normal newborn
Two-day stay
DRG 391

List of Outpatient Procedures*

Operations on the Nervous System
Epidural pain block
CPT-4 62278 Injection of anesthetic substance (including narcotics), diagnostic or therapeutic; lumbar or caudal epidural, single
ICD-9 03.91 Injection of anesthetic into spinal canal for analgesia
Carpal tunnel release
CPT-4 64721 Neuroplasty or transposition, or both; median nerve at carpal tunnel
ICD-9 04.43 Release of carpal tunnel

Operations on the Eye
Radial keratotomy (surgical correction of myopia)
CPT-4 65771 Radial keratotomy
ICD-9 11.75 Radial keratotomy
Cataract removal, with intraocular lens implant
CPT-4 66983 Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)
CPT-4 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (for example, irrigation and aspiration or phacoemulsification)
ICD-9 13.19 Other intracapsular extraction of lens, plus
ICD-9 13.71 Insertion of intraocular lens prosthesis at time of cataract extraction, one (1) stage
ICD-9 13.59 Other extracapsular extraction of lens, plus
ICD-9 13.71 Insertion of intraocular lens prosthesis at time of cataract extraction, one (1) stage
Removal of secondary cataract
CPT-4 66821 Discussion of secondary membranous cataract (opacified posterior lens capsule, anterior haloid, or both); laser surgery (for example, YAG laser) (one (1) or more stages)
ICD-9 13.64 Discussion of secondary membrane (after cataract)
Secondary insertion of intraocular lens/Exchange of intraocular lens
CPT-4 66985 Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
CPT-4 66986 Exchange of intraocular lens
ICD-9 13.72 Secondary insertion of intraocular lens prosthesis

Operations on the Ear, Nose, Mouth and Pharynx
Myringotomy, with or without tubes
CPT-4 69421 Myringotomy including aspiration or eustachian tube inflation, or both, requiring general anesthesia
CPT-4 69436 Tympanostomy (requiring insertion of ventilating tube), general anesthesia
ICD-9 20.01 Myringotomy with insertion of tube
Nasal fracture, closed reduction
CPT-4 21320 Manipulative treatment, nasal bone fracture; with stabilization
ICD-9 21.71 Closed reduction of nasal fracture
Septoplasty
CPT-4 30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
ICD-9 21.88 Other septoplasty
Tonsillectomy without adenoidectomy
CPT-4 42825 Tonsillectomy, primary or secondary; under age 12
CPT-4 42826 age 12 or over
ICD-9 28.2 Tonsillectomy without adenoidectomy
Tonsillectomy with adenoidectomy
CPT-4 42820 Tonsillectomy and adenoidectomy; under age 12
CPT-4 42821 age 12 or over
ICD-9 28.3 Tonsillectomy with adenoidectomy

Operations on the Cardiovascular System
- Cardiac catheterization, left heart
  - CPT-4 93510 Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous
  - CPT-4 93511 by cutdown
  - CPT-4 93514 Left heart catheterization by left ventricular puncture
  - CPT-4 93524 Combined transseptal and retrograde left heart catheterization
  - ICD-9 37.22 Left heart cardiac catheterization
- Varicose vein ligation and stripping
  - CPT-4 37720 Ligation and division and complete stripping of long or short saphenous veins
  - ICD-9 38.5 Ligation and stripping of varicose veins

Endoscopic Procedures
- Bronchoscopy, diagnostic
  - CPT-4 31622 Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washing or brushing
  - ICD-9 33.22 Fiber-optic bronchoscopy
  - ICD-9 33.23 Other bronchoscopy
- Dilation of esophagus
  - CPT-4 43455 Dilation of esophagus, by balloon or dilator; under fluoroscopic guidance
  - CPT-4 43456 retrograde
  - ICD-9 42.92 Dilation of esophagus
- Upper GI endoscopy, diagnostic
  - CPT-4 43235 Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum, jejunum, or both, as appropriate; complex diagnostic
  - ICD-9 44.13 Other endoscopy of small intestine
- Endoscopy of small intestine, diagnostic
  - CPT-4 44360 Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; diagnostic
  - ICD-9 45.13 Other endoscopy of small intestine
- Colonoscopy, diagnostic
  - CPT-4 45378 Colonoscopy, fiber-optic, beyond splenic flexure; diagnostic, with or without colon decompression
  - ICD-9 45.23 Colonoscopy
- Sigmoidoscopy, diagnostic
  - CPT-4 45330 Sigmoidoscopy, flexible fiber-optic; diagnostic
  - ICD-9 45.24 Flexible sigmoidoscopy

Operations on the Digestive System
- Cholecystectomy (gall bladder removal)
  - CPT-4 49310 Laparoscopy, surgical; cholecystectomy (any method)
  - ICD-9 51.23 Laparoscopic cholecystectomy
- Inguinal hernia repair
  - CPT-4 49500 Repair inguinal hernia, under age 5 years, with or without hydrocelectomy
  - CPT-4 49505 Repair inguinal hernia, age 5 or over
  - ICD-9 53.00 Unilateral repair of inguinal hernia, not otherwise specified
  - ICD-9 53.01 Repair of direct inguinal hernia
  - ICD-9 53.02 Repair of indirect inguinal hernia
- Diagnostic laparoscopy
  - CPT-4 58980 Laparoscopy, diagnostic (separate procedure)
  - ICD-9 54.21 Laparoscopy
- Cystoscopy
  - CPT-4 52000 Cystourethroscopy (separate procedure)
  - ICD-9 57.32 Other cystoscopy

Sterilization
- Vasectomy
  - CPT-4 55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
  - ICD-9 63.73 Vasectomy
- Tubal ligation
  - CPT-4 58982 Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
  - CPT-4 58983 with occlusion of oviducts by device (for example, band, clip, or Falope ring)
  - ICD-9 66.21 Bilateral endoscopic ligation and crushing of fallopian tubes
  - ICD-9 66.22 Bilateral endoscopic ligation and division of fallopian tubes
  - ICD-9 66.29 Other bilateral endoscopic destruction or occlusion of fallopian tubes

Gynecological Operations
- Conization of cervix
  - CPT-4 57520 Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair (any method)
  - ICD-9 67.2 Conization of cervix
- Laser destruction of cervical lesion
  - CPT-4 57513 Cauterization of cervix; laser ablation
  - ICD-9 67.39 Other excision or destruction of lesion or tissue of cervix
- Diagnostic D & C
  - CPT-4 58120 Dilation and curettage, diagnostic therapeutic (nonobstetrical), or both
  - ICD-9 69.09 Other dilation and curettage

Operations on the Musculoskeletal System
- Bunionectomy
  - CPT-4 28110 Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
  - CPT-4 28290 Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)
  - CPT-4 28292 Keller, McBride or Mayo type procedure
  - CPT-4 28293 resection of joint with implant
  - CPT-4 28294 with tendon transplants (Joplin type procedure)
  - CPT-4 28296 with metatarsal osteotomy (for example, Mitchell, Chevron, or concentric type procedures)
  - CPT-4 28297 Lapidus type procedure
  - CPT-4 28298 by phalanx osteotomy
  - CPT-4 28299 by other methods (for example, double osteotomy)
  - ICD-9 77.51 Bunionectomy with soft tissue correction and osteotomy of the first metatarsal
  - ICD-9 77.52 Bunionectomy with soft tissue correction and arthrodesis
  - ICD-9 77.53 Other bunionectomy with soft tissue correction
  - ICD-9 77.54 Excision or correction of bunionette
  - ICD-9 77.57 Repair of claw toe
  - ICD-9 77.58 Other excision, fusion and repair of toes
  - ICD-9 77.59 Other bunionectomy
- Hammertoe correction
  - CPT-4 28285 Hammertoe operation; one toe (for example, interphalangeal fusion, filleting, phalangectomy)
  - ICD-9 77.56 Repair of hammertoe
- Knee arthroscopy, diagnostic
  - CPT-4 29870 Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
  - ICD-9 80.26 Arthroscopy, knee
  - ICD-9 80.36 Biopsy of joint structure, knee
- Knee arthroscopy, removal of cartilage
  - CPT-4 29881 Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral including any meniscal shaving)
  - ICD-9 80.6 Excision of semilunar cartilage of knee
- Ganglionectomy, hand or wrist
  - CPT-4 25111 Excision of ganglion, wrist (dorsal or volar); primary
  - CPT-4 26160 Excision of lesion of tendon sheath or capsule (for example, cyst, mucous cyst, or ganglion), hand or finger
  - ICD-9 82.21 Excision of lesion of tendon sheath of hand

Operations on the Integumentary System
- Breast biopsy, incisional
  - CPT-4 19101 Biopsy of breast; incisional
  - ICD-9 85.12 Open biopsy of breast
- Removal of breast lesion
  - CPT-4 19120 Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion or nipple lesion (except 19140), male or female, one or more lesions
  - ICD-9 85.21 Local excision of lesion of breast

Miscellaneous Diagnostic and Therapeutic Procedures
CAT scan of head, without contrast
CPT-4 70450 Computerized axial tomography, head or brain; without contrast material
ICD-9 87.03 Computerized axial tomography of head
CAT scan of head, with and without contrast
CPT-4 70470 Computerized axial tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
ICD-9 87.03 Computerized axial tomography of head
Contrast myelogram of spine
CPT-4 61055 Cisternal or lateral cervical (C1-C2) puncture; with injection of drug or other substance for diagnosis or treatment (C1-C2) or
CPT-4 62284 Injection procedure for myelography or computerized axial tomography, or both, spinal (other than C1-C2 and posterior fossa), plus
CPT-4 72270 Myelography, entire spinal canal, radiological supervision and interpretation
ICD-9 87.21 Contrast myelogram
Mammography
CPT-4 76092 Screening mammography, bilateral (two view film study of each breast)
ICD-9 87.37 Other mammography (X-ray imaging of the breast, other than xerography)
CAT scan of abdomen, without contrast
CPT-4 74150 Computerized axial tomography, abdomen; without contrast material
ICD-9 88.01 Computerized axial tomography of abdomen
CAT scan of abdomen, with and without contrast
CPT-4 74170 Computerized axial tomography, abdomen; without contrast material, followed by contrast material(s) and further sections
ICD-9 88.01 Computerized axial tomography of abdomen
Diagnostic ultrasound, abdomen and retroperitoneum
CPT-4 76700 Echography, abdominal, B-scan or real time with image documentation, or both; complete
CPT-4 76770 Echography, retroperitoneal (for example, renal, aorta, nodes), B-scan or real time with image documentation, or both; complete
ICD-9 88.76 Diagnostic ultrasound of abdomen and retroperitoneum
Diagnostic ultrasound, gravid uterus
CPT-4 76805 Echography, pregnant uterus, B-scan or real time with image documentation, or both; complete (complete fetal and maternal evaluation)
CPT-4 76810 complete (complete fetal and maternal evaluation), multiple gestation, after the first trimester
ICD-9 88.78 Diagnostic ultrasound of gravid uterus
Magnetic resonance imaging, brain, without contrast
CPT-4 70551 Magnetic resonance (for example, proton) imaging, brain (including brain stem); without contrast material
ICD-9 88.91 Magnetic resonance imaging of brain and brain stem
Magnetic resonance imaging, brain, with and without contrast
CPT-4 70553 Magnetic resonance (for example, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
ICD-9 88.91 Magnetic resonance imaging of brain and brain stem
Magnetic resonance imaging, spinal canal, without contrast
CPT-4 72141 Magnetic resonance (for example, proton) imaging, spinal canal and contents, cervical; without contrast material
CPT-4 72146 Magnetic resonance (for example, proton) imaging, spinal canal and contents, thoracic; without contrast material
CPT-4 72148 Magnetic resonance (for example, proton) imaging, spinal canal and contents, lumbar; without contrast material
ICD-9 88.93 Magnetic resonance imaging of spinal canal
Magnetic resonance imaging, spinal canal, with and without contrast
CPT-4 72156 Magnetic resonance (for example, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical
CPT-4 72157 thoracic
CPT-4 72158 lumbar
ICD-9 88.93 Magnetic resonance imaging of spinal canal
Treadmill stress test
CPT-4 93015 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise or pharmacological stress, or both; continuous electrocardiographic monitoring, with interpretation and report
ICD-9 89.41 Cardiovascular stress test using treadmill
Electrocardiogram
CPT-4 93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
ICD-9 89.52 Electrocardiogram
Extracorporeal shockwave lithotripsy, kidney, ureter or bladder, or any combination of these
CPT-4 50590 Lithotripsy, extracorporeal shockwave
ICD-9 98.51 Extracorporeal shock wave lithotripsy (ESWL) of the kidney, ureter or bladder, or any combination of these

*Charges for outpatient procedures shall include the facility's total customary charges for a specific procedure or group of procedures defined according to ICD-9-CM or CPT-4 codes. Charges shall include fees associated with the preparation of the patient (preoperative phase), performance of the procedure (intraoperative phase) and recovery (postoperative phase): Preoperative phase includes those services and procedures that prepare the patient for the surgical procedure. It shall include, but is not limited to, charges for standard preoperative diagnostic laboratory testing, radiological services, preparatory pharmaceuticals (preoperative medications), skin preparation supplies, and the like. Intraoperative phase includes those services and procedures during the period of time of the actual surgical procedure itself (as identified by ICD-9-CM or CPT-4 code) as performed to eliminate or improve the patient's diagnostic condition. It shall include, but is not limited to, room charges for the surgery suite, anesthesia and other intraoperative pharmaceuticals, equipment and supplies (drapes/barriers, electrocautery tips and grounding pads, specialized scalpel blades, dressing materials, casting materials and orthopedic supplies, and the like). Postoperative phase includes those services and procedures that are provided to the patient from the point at which the patient exits the surgery suite to the point at which the patient is discharged from the facility. It shall include, but is not limited to, charges for use of the recovery room, dressings, pharmaceuticals, respiratory therapy, supplies and the like. Professional fees for facility-based radiologists, pathologists, anesthesiologists and the like, if they are reported by the facility, shall be reported separately.

AUTHORITY: section 192.667, RSMo 2000. Emergency rule filed Nov. 4, 1992, effective Nov. 14, 1992, expired March 13, 1993. Emergency rule filed March 4, 1993, effective March 14, 1993, expired July 11, 1993. Original rule filed Nov. 4, 1992, effective June 7, 1993. Emergency amendment filed April 1, 1993, effective April 11, 1993, expired Aug. 8, 1993. Emergency amendment filed Aug. 10, 1993, effective Aug. 20, 1993, expired Nov. 18, 1993. Amended: Filed April 1, 1993, effective Dec. 9, 1993. Amended: Filed April 13, 2001, effective Oct. 30, 2001.*

**Original authority: 192.667, RSMo 1992, amended 1993, 1995.*

19 CSR 10-33.030 Reporting Financial Data by Hospitals

PURPOSE: This rule establishes procedures for reporting financial data by hospitals to the Department of Health.

(1) Hospitals shall report the financial data listed in Exhibit D of this rule, included herein, for the previous fiscal year to the Department of Health by April 15 of each year starting in 1993. If any data element has been submitted previously to the Division of Medical Services of the Department of Social Services, the hospital does not have to report that data to the Department of Health. The Department of Health shall notify each hospital what data elements are not available from the Division of Medical Services.

(2) Hospitals may provide the financial data directly or through an association to the Department of Health from the financial section of the annual licensing survey.

(3) The Department of Health shall develop and publish reports pertaining to individual hospitals. The reports and the data they contain shall be public information and may be released on magnetic media. The Department of Health shall make the reports and data available for a reasonable charge based upon incurred costs.

(4) The Department of Health may develop reports and release data upon request which do not directly or indirectly identify individual hospitals. The reports and data shall be public information and may be released on magnetic media. The Department of Health shall make the reports and data available for a reasonable charge based upon incurred costs.

(5) Any provider which determines it temporarily will be unable to comply with any of the provisions of this rule or with the provisions of a previously-submitted plan of correction can provide the Department of Health with written notification of the expected deficiencies and a written plan of correction. The notification and plan of correction shall include the section number and text of the rule in question, specific reasons why the provider cannot comply with the rule, an explanation of any extenuating factors which may be relevant, the means the provider will employ for correcting the expected deficiency and the date by which each corrective measure will be completed.

(6) Any provider which is not in compliance with this rule shall be notified in writing by the Department of Health. The notification shall specify the deficiency and the action which must be taken to be in compliance. The chief executive officer or designee shall have ten (10) working days following receipt of the written notification of noncompliance to provide the Department of Health with a written plan for correcting the deficiency. The plan of correction shall specify the means the provider will employ for correcting the cited deficiency and the date that each corrective measure will be completed.

(7) Upon receipt of a required plan of correction, the Department of Health shall review the plan to determine the appropriateness of the corrective action. If the plan is acceptable, the Department of Health shall notify the chief executive officer or designee in writing and indicate that implementation of the plan should proceed. If the plan is not acceptable, the Department of Health shall notify the chief executive officer or designee in writing and indicate the reasons why the plan was not accepted. A revised, acceptable plan of correction shall be provided to the Department of Health within ten (10) working days.

(8) Failure of the provider to submit an acceptable plan of correction within the required time shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the director of the Department of Health.

(9) Failure of any provider to follow its accepted plan of correction shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the director of the Department of Health.

(10) Any provider in continued and substantial noncompliance with this rule shall be notified by registered mail and reported by the Department of Health to its Bureau of Hospital Licensing and Certification, Bureau of Narcotics and Dangerous Drugs, Bureau of Emergency Medical Services, Bureau of Home Health Licensing and Certification, Bureau of Radiological Health, State Public Health Laboratory, Bureau of Special Health Care Needs, the Division of Medical Services of the Department of Social Services, the Division of Vocational Rehabilitation of the Department of Elementary and Secondary Education and to other state agencies that administer a program with provider participation. The Department of Health shall notify the agencies that the provider is no longer eligible for participation in a state program.

(11) Any provider that has been declared to be ineligible for participation in a state program shall be eligible for reinstatement by correcting the deficiencies and making written application for reinstatement to the Department of Health. Any provider meeting the requirements for reinstatement shall be notified by registered mail. The Department of Health shall notify state agencies that administer a program with provider participation that the provider's eligibility for participation in a state program has been reinstated.

EXHIBIT D

Financial Data Elements

BALANCE SHEET*

1a.	Cash and cash equivalents	_____	
1b.	Net patient accounts receivable	_____	
1c.	Other current assets	_____	
1d.	Total current assets		_____
2a.	Fixed assets at cost	_____	
2b.	Less: accumulated depreciation	_____	
2c.	Fixed assets (net)		_____
3.	Other assets		_____
4.	Total assets		_____
5.	Current liabilities		_____
6.	Long-term debt		_____
7.	Other long-term liabilities		_____
8.	Fund balance		_____
9.	Total liabilities and fund balance		_____

INCOME STATEMENT**

1a.	Inpatient revenue	_____	
1b.	Outpatient revenue	_____	
1c.	Total gross patient revenue		_____
2a.	Charity care	_____	
2b.	Other allowances and deductions	_____	
2c.	Total deductions and allowances		_____
3.	Net patient revenue		_____
4.	Other revenue		_____
5.	Total revenue		_____
6a.	Payroll expenses	_____	
6b.	Employee benefits	_____	
6c.	Depreciation expense	_____	
6d.	Bad debt expense	_____	
6e.	All other operating expenses	_____	
6f.	Total operating expenses		_____
7.	Net income from operations		_____
8a.	Investment income	_____	
8b.	Contributions	_____	
8c.	Tax support and other subsidies	_____	
8d.	Miscellaneous gains and losses	_____	
8e.	Nonoperating gains and losses		_____
9.	Net income before extraordinary and other nonrecurring items		_____
10.	Extraordinary gains and losses		_____
11.	Net income		_____

SUPPLEMENTAL ITEMS***

1.	If depreciation is funded, balance at end of reporting period		_____
2a.	Medicare gross patient revenue	_____	
2b.	Medicaid gross patient revenue	_____	
2c.	Other government patient revenue	_____	
2d.	Nongovernment patient revenue	_____	

Definitions for Exhibit D

Balance Sheet*

1a. *Cash and cash equivalents* means money on hand, and includes money in checking accounts, time deposits, temporary cash investments and uninvested funds held by investment custodians.

1b. *Net patient accounts receivable* means accounts receivable, net of estimated uncollectibles.

1c. *Other current assets* means other accounts receivable, notes receivable and may include the current portion of assets whose use is limited, prepaid expenses, inventory and short-term investments.

1d. *Total current assets* means the sum of lines 1a. through 1c.

2a. *Fixed assets at cost* means land, land improvements, buildings and improvements, leasehold improvements, equipment (fixed and movable), leased property and equipment, and construction in progress, at cost.

2b. *Accumulated depreciation* means depreciation and amortization.

2c. *Fixed assets (net)* means fixed assets at cost (line 2a.) less accumulated depreciation (line 2b.).

3. *Other assets* means all other assets, and may include deferred financing costs, unamortized bond issue costs, investment in affiliated company, deferred third-party reimbursement and other assets.

4. *Total assets* means the sum of lines 1d., 2c. and 3.

5. *Current liabilities* means those which will be discharged with current assets, and may include notes payable to banks; the current portion of long-term debt; accounts payable; advances from and amounts payable to third-party payers for estimated and final reimbursement settlements; refunds to and deposits from patients and others; deferred revenue; accrued salaries and payroll taxes; and other accruals such as pension or profit-sharing contributions, compensated absences, and income and other taxes.

6. *Long-term debt* means notes payable, mortgages payable, capital leases, bonds payable and loans/contracts payable.

7. *Other long-term liabilities* means other long-term obligations, and may include estimated malpractice costs, deferred compensation payable, deferred third-party reimbursement and accrued pension/deferred pension liability.

8. *Fund balance* means the excess of assets over liabilities (net equity). An excess of liabilities over assets is reflected as a deficit.

9. *Total liabilities and fund balance* means the sum of lines 5.–8. Must agree with total assets, line 4.

Income Statement**

1a. *Inpatient revenue* means full hospital charges for all hospital services to inpatients.

1b. *Outpatient revenue* means full hospital charges for all hospital services to outpatients.

1c. *Total gross patient revenue* means the sum of lines 1a. and 1b. Full hospital charges for all hospital patient services before considering any deductions for charity care or contractual allowances.

2b. *Other allowances and deductions* means revenue deductions incurred in treating patients other than charity patients, including Medicare, Medicaid, other insured and uninsured patients. It includes courtesy discounts given to employees and others. It does not include bad debt expense, which is to be reported as an operating expense (line 6d.).

2c. *Total allowance and deductions* means the sum of lines 2a. and 2b.

3. *Net patient revenue* means total gross revenue (line 2.) less total allowances and deductions (line 2c.).

4. *Other revenue* means revenue from services other than health care provided to patients and residents, and includes sales and services to nonpatients. This revenue arises from the normal day-to-day operations of the health care entity. Other revenues may include: revenue such as gifts, grants, or endowment income restricted by donors to finance charity care; revenue from educational programs; revenue from research and other gifts and grants; revenue from miscellaneous sources, such as rental of facility space, sales of medical and pharmacy supplies, fees charged for transcripts for attorneys, insurance companies and others, proceeds from the sale of cafeteria meals and guest trays, proceeds from the sale of scrap, used X-ray film, and proceeds from sales at gift shops, snack bars, newsstands, parking lots, vending machines and other service facilities operated by the health care entity.

5. *Total revenue* means the sum of lines 3. and 4.

6a. *Payroll expenses* means salaries and wages paid to employees of the health care entity.

6b. *Employee benefits* means Social Security, group insurance, retirement benefits, Workers' Compensation, unemployment insurance and others.

6c. *Depreciation expense* means depreciation and amortization of property and equipment recorded for the reporting period.

6d. *Bad debt expense* means revenue amounts deemed uncollectible primarily because of a patient's unwillingness to pay as determined after collection efforts based upon sound credit and collection policies. It does not include charity care, which is to be reported on line 2a.

6e. *All other operating expenses* means expenses for professional fees, interest, supplies, purchased services, utilities, income taxes, operating losses and any other expenses not included in the above categories.

6f. *Total operating expenses* means the sum of lines 6a.–6e.

7. *Income from operations* means total revenue (line 5.) less total operating expenses (line 6f.).

8a. *Investment income* means return on investments of general funds, except that investment income and realized gains and losses on borrowed funds held by a trustee, investment income on malpractice trust funds and investment income that is essential to the ongoing major or central operations are included in other revenue (line 4.).

8b. *Contributions* means contributions, donations and bequests for general operating purposes from foundations, similar groups or individuals, or any combination of these.

8c. *Tax support and other subsidies* means tax levies and other subsidies from governmental or community agencies received for general support of the entity.

8d. *Miscellaneous gains and losses* means all other gains and losses from a provider's peripheral or incidental transactions, such as gain or loss on sale of health care entity properties; net rentals of facilities used in the operation of the entity; and term endowment funds that are available for general operating purposes upon termination of restrictions.

8e. *Nonoperating gains and losses* means the sum of lines 8a.–8d.

9. *Net income before extraordinary and other nonrecurring items* means the sum of net income from operations (line 7.) and nonoperating gains and losses (line 8e.).

10. *Extraordinary gains and losses* means gains or losses unusual in amount and nonrecurring in nature that do not result from normal operating activities. Events or transactions that occur frequently in the health care environment, such as large, unrestricted gifts, cannot be regarded as extraordinary, regardless of their financial effect, and are to be included in ordinary income.

11. *Net income* means the sum of lines 9. and 10.

Supplemental Items***

1. *Funded depreciation* means cash resources which have been set aside and accumulated for the purpose of financing the renewal or replacement of plant assets.

2a. *Medicare gross patient revenue* means full hospital charges for all hospital services provided to Medicare patients.

2b. *Medicaid gross patient revenue* means full hospital charges for all hospital services provided to Medicaid patients.

2c. *Other government patient revenue* means full hospital charges for all hospital services provided to other government patients, including CHAMPUS, government retirement and Crippled Children's Service.

2d. *Nongovernment patient revenue* means full hospital charges for all hospital services provided to nongovernment patients, including those with private insurance, those belonging to HMOs or PPOs, and those without insurance.

AUTHORITY: section 192.667, RSMo 2000. Emergency rule filed Nov. 4, 1992, effective Nov. 14, 1992, expired March 13, 1993. Emergency rule filed March 4, 1993, effective March 14, 1993, expired July 11, 1993. Original rule filed Nov. 4, 1992, effective June 7, 1993. Emergency amendment filed April 1, 1993, effective April 11, 1993, expired Aug. 8, 1993. Emergency amendment filed Aug. 10, 1993, effective Aug. 20, 1993, expired Nov. 18, 1993. Amended: Filed April 1, 1993, effective Dec. 9, 1993. Amended: Filed April 13, 2001, effective Oct. 30, 2001.*

**Original authority: 192.667, RSMo 1992, amended 1993, 1995.*

19 CSR 10-33.040 Electronic Reporting of Patient Abstract Data by Hospitals for Public Health Syndromic Surveillance

PURPOSE: This rule establishes procedures for secure electronic reporting of patient abstract data for inpatients and outpatients by hospitals to the Department of Health and Senior Services for the purpose of conducting epidemiologic monitoring and studies and publishing information to safeguard the health of the citizens of Missouri as authorized by sections 192.020, 192.067 and 192.667, RSMo.

(1) The following definitions shall be used in the interpretation of this rule in addition to the definitions found in 19 CSR 10-33.010:

(A) Batch message file means the transmission of a file containing multiple discrete standard electronic messages to the department from the hospital data system on a periodic basis less than real time.

(B) Chief complaint means the textual literal or ICD-9-CM code or both pertaining to the initial complaint a patient stated during an acute care hospital encounter.

(C) Data encryption means the electronic obfuscation of data within an electronic message using industry standard practices for encryption including, but not limited to: Public Key Infrastructure (PKI), digital certificates/signatures, department generated symmetric keys, or by secure message transport protocols. Minimum requirements will be tripleDES 128-bit encryption.

(D) Default standard message means a standard electronic message meeting HL7 2.3.1 Admission, Discharge, and Transfer (ADT) specifications as identified in Exhibit A, included herein.

(E) Acute care hospital encounter means patients seen in the emergency room, urgent care and inpatient admissions of a hospital.

(F) Real time message means the transmission of discrete standard electronic messages to the department as they are generated by the hospital data system.

(G) Secure message transport protocol means a method of sending electronic data to the department in a way that prevents unauthorized access to the data. Possible methods include: Virtual Private Network (VPN), Secure File Transport Protocol (SFTP), secure socket layer (HTTPS/SSL), Secure SHell (SSH), encrypted files using TCP/IP, or other secure transmission protocol agreed upon by the hospital and the department.

(H) Standard electronic message means a real time message or batch message file meeting national or international standards for the electronic interchange of data. Standards include, but are not limited to, Health Level 7 (HL7), Extensible Mark-up Language (XML), Electronic Business XML (ebXML), Electronic Data Interchange (EDI), and other standards as they become available.

(I) Hospital means a hospital as defined in section 197.020, RSMo. For the purposes of this rule only, hospital shall not include a hospital in a rural area as defined in section 191.500, RSMo; a hospital designated by the Health Resources Services Administration as a small rural hospital; a hospital licensed as a psychiatric or a rehabilitative hospital; or a hospital without an emergency room. Following the completion of implementation of plans submitted to and approved by the department pursuant to section (4), the department may review the need to expand this definition to include hospitals in a rural area as defined in section 191.500, RSMo or hospitals designated by the Health Resources Services Administration as a small rural hospital.

(2) All hospitals shall submit to the department a minimum data set on acute care hospital encounters occurring after the date proposed by the hospital and approved by the department. This date shall be either between April 2004 and January 2007 or an earlier date agreed upon by the hospital and the department. Before April 2004, the department shall conduct a pilot study with hospitals that volunteer to participate in the pilot study. At the sole discretion of the department, the pilot study may be extended. If the pilot study is continued, the department shall inform hospitals that their planned implementation date has been postponed to a new date as determined by the department. The data shall be submitted as a default standard electronic message or other format as agreed upon by the hospital and the department, using secure message transport protocols and data encryption.

(A) The minimum dataset shall be submitted a minimum of once per day as a batch message file containing the previous day's hospital encounters and updates.

(B) Real time messages will be default standard electronic messages. Other message formats must be approved and agreed upon by the department prior to submission of real time messages.

(3) The minimum dataset shall include: record type, hospital identifier, unique encounter identifier, type of encounter, place of service, patient medical record number, patient name, patient Social Security number, patient birth date, patient sex, patient race, patient ethnicity, residence address, city of residence, state of residence, zip code, county code, admission date, type of admission, and chief complaint. See Exhibit A and Exhibit B, included herein, for default standard electronic message specifications.

(4) Every hospital shall submit to the department by November 1, 2003 a plan that specifies how and when they will submit data to the department in compliance with section (2) of this rule. This plan may be revised by the hospital, with the approval of the department, in the event the hospital's capacity to report electronic messages changes to support the default standard electronic message as either batch or real time messages. The hospital shall notify the department by sixty (60) days in advance of the date they plan to change the method in which they report data. This plan shall include but not be limited to:

(A) Timing of messages either real time or batch;

(B) Secure message transport protocols to be used when submitting data to the department;

(C) Proposed format of data if the hospital is not able to conform to the default standard electronic message defined in Exhibit A or Exhibit B;

(D) Proposed format code set domain values if the hospital is not able to conform to the code sets defined in Exhibit A or Exhibit B;

(E) Hospital technical contact(s) and contact information for the department to utilize in the event technical assistance or support is necessary;

(F) Expected date to begin sending messages;

(G) If a change request, the reason for change.

(5) Hospitals shall notify the department by sixty (60) days in advance if they plan to submit the required data to the department through an association or related organization with which the department has a binding agreement to obtain data. Providers selecting this option are responsible for ensuring that the data meet the data standards defined in this rule and are submitted to the association or related organization so the time schedule in section (2) of this rule is met. The association or related organization is responsible for ensuring that the data are provided to the department and conform to the specifications listed in Exhibit A of this rule, meeting the time schedule of section (2) of this rule.

(6) Hospitals may submit data directly to the department or through a third party acting as their agent, other than one with which the department has a binding agreement. Providers selecting this option are responsible for ensuring that all data specifications conform to the requirements of this rule.

(7) The department may release patient data on hospital encounters to a public health authority to assist the agency in fulfilling its public health mission. This data shall not be re-released in any form by the public health authority without the prior authorization of the department. Authorization for subsequent release of the data shall be considered only if the proposed release does not identify a patient, physician or provider. However, the department may authorize contact with the patient, physician or provider based upon the information supplied. The physician and provider that provided care to a patient shall be informed by the public health authority of any proposed contact with a patient.

(8) Any hospital which determines it will be temporarily unable to comply with any of the provisions of this rule or with the provisions of a previously submitted plan or plan of correction can provide the department with written notification of the expected deficiencies and a written plan of correction. This notification and plan of correction shall include the section number and text of the rule in question, specific reasons why the provider cannot comply with the rule, an explanation of any extenuating factors which may be relevant, the means the provider will employ for correcting the expected deficiency, and the date by which each corrective measure will be completed.

(9) Any hospital, which is not in compliance with these rules, shall be notified in writing by the department. The notification shall specify the deficiency and the action, which must be taken to be in compliance. The chief executive officer or designee shall have ten (10) working days following receipt of the written notification of noncompliance to provide the department with a written plan for correcting the deficiency. The plan of correction shall specify the means the provider will employ for correcting the cited deficiency and the date that each corrective measure will be completed.

(10) Upon receipt of a required plan of correction, the department shall review the plan to determine the appropriateness of the corrective action. If the plan is acceptable, the department shall notify the chief executive officer or designee in writing and indicate that implementation of the plan should proceed. If the plan is not acceptable, the department shall notify the chief executive officer or designee in writing and indicate the reasons why the plan was not accepted. A revised, acceptable plan of correction shall be provided to the department within ten (10) working days.

(11) Failure of the hospital to submit an acceptable plan of correction within the required time shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the director of the department.

(12) Failure of any hospital to follow its accepted plan of correction shall be considered continued and substantial noncompliance with this rule unless determined otherwise by the director of the department.

(13) Any hospital in continued and substantial noncompliance with this rule shall be notified by registered mail and reported by the department to its Bureau of Hospital Licensing and Certification, Bureau of Narcotics and Dangerous Drugs, Bureau of Emergency Medical Services, Bureau of Home Health Licensing and Certification, Bureau of Radiological Health, State Public Health Laboratory, Bureau of Special Health Care Needs, the Division of Medical Services of the Department of Social Services, the Division of Vocational Rehabilitation of the Department of Elementary and Secondary Education and to other state agencies that administer a program with provider participation. The department shall notify the agencies that the provider is no longer eligible for participation in a state program.

(14) Any hospital that has been declared to be ineligible for participation in a state program shall be eligible for reinstatement by correcting the deficiencies and making written application for reinstatement to the department. Any provider meeting the requirements for reinstatement shall be notified by registered mail. The department shall notify state agencies that administer a program with provider participation that the provider's eligibility for participation in a state program has been reinstated.

19 CSR 10-33.040 HESS HL7 Exhibit A

Introduction

For the purposes of this rule, the HL7 v 2.3.1 message format will be used. ADT messages with a number of different event codes may carry information about chief complaint including A01 through A18. A04, Register a patient, will often be used to signal the beginning of a visit to the Emergency Department. A01, Admit/visit notification, and A08, Update patient information, may also be used to indicate changes to an initial A04 registration such as assigned or updated diagnosis or admission of an ER patient.

A general ADT message has the segment structure:

Segment	Description	HL7 Chapter
MSH	Message Header	2
EVN	Event Type	3
PID	Patient Identification	3
[PD1]	Additional Demographics	3
[{ NK1 }]	Next of Kin /Associated Parties	3
PV1	Patient Visit	3
[PV2]	Patient Visit - Additional Info.	3
[{ DB1 }]	Disability Information	3
[{ OBX }]	Observation/Result	7
[{ AL1 }]	Allergy Information	3
[{ DG1 }]	Diagnosis Information	6
[DRG]	Diagnosis Related Group	6
{ { PR1	Procedures	6
[{ROL}]	Role	12
}}		
[{ GT1 }]	Guarantor	6
[		
{ IN1	Insurance	6
[IN2]	Insurance Additional Info.	6
[{IN3}]	Insurance Add'l Info - Cert.	6
]		
]		
[ACC]	Accident Information	6
[UB1]	Universal Bill Information	6
[UB2]	Universal Bill 92 Information	6

Required data elements for public health syndromic surveillance reporting are located in segments MSH, PID, PV1, and PV2. The rest of this exhibit identifies the specific formats for these segments. Elements with an optionality (OPT) of "R" are required. All other elements are not required, therefore are not described in the details of each message segment. Complete HL7 documentation can be found at http://www.hl7.org/. These specifications are in compliance with the specifications for HL7 version 2.3.1.

MSH Segment – Message Header

The message header segment (MSH) defines the intent, source, destination, and some specifics of the syntax of a message. The attributes of the message header segment are listed in the table below.

MSH Attributes

SEQ	LEN	DT	OPT	TBL#	RP/#	ITEM#	Element Name
1	1	ST	R			00001	Field Separator
2	4	ST	R			00002	Encoding Characters
3	180	HD	O			00003	Sending Application
4	180	HD	R			00004	Sending Facility
5	180	HD	R			00005	Receiving Application
6	180	HD	R			00006	Receiving Facility
7	26	TS	R			00007	Date/Time Of Message
8	40	ST	O			00008	Security
9	7	CM	R	0076		00009	Message Type
10	20	ST	O			00010	Message Control ID
11	3	PT	R			00011	Processing ID
12	8	ID	R	0104		00012	Version ID
13	15	NM	O			00013	Sequence Number
14	180	ST	O			00014	Continuation Pointer
15	2	ID	O	0155		00015	Accept Acknowledgment Type
16	2	ID	O	0155		00016	Application Acknowledgment Type
17	2	ID	O			00017	Country Code
18	6	ID	O	0211	Y/3	00692	Character Set
19	60	CE	O			00693	Principal Language Of Message

Example Segment of MSH:

MSH|^~\&||MO Hospital^013319934^NPI|MOHESS|MODHSS|200302171830||ADT^A04||P|2.3.1<cr>

If elements that contain no data (e.g., "||") appear at the end of a segment, HL7 allows the elements to not appear. For example, the message above has no data populating elements 13-19, thus, the segment ends at element 12 (i.e., ...|2.3.1).

2.24.1.0 MSH field definitions

Field separator (ST) 00001

Definition: This field contains the separator between the segment ID and the first real field, MSH-2-encoding characters. As such it serves as the separator and defines the character to be used as a separator for the rest of the message. Recommended value is |, (ASCII 124).

Encoding characters (ST) 00002

Definition: This field contains the four characters in the following order: the component separator, repetition separator, escape character, and subcomponent separator. Expected values will be ^~\&, (ASCII 94, 126, 92, and 38, respectively

19 CSR 10-33.040 HESS HL7 Exhibit A

Sending facility (EI) 00004

```
Components:  <namespace ID (IS)> ^ <universal ID (ST)> ^ <universal ID type (ID)>
```

This element contains the name of the originating hospital, National Provider Identifier (NPI), and "NPI" as the universal type. In the absence of an NPI, the hospital's Medicaid Provider ID may be used with the universal ID type identified as "MCID"

namespace ID	Name of originating hospital
universal ID	Unique NPI number of originating hospital
universal ID type	"NPI"

|MO Hospital^013319934^NPI|

Receiving application (EI) 00005

This element will always contain "MOHESS" for Missouri Hospital Electronic Syndromic Surveillance.

Receiving facility (EI) 00006

This element will always contain "MODHSS" for the Missouri Department of Health and Senior Services.

Date/time of message (TS) 00007

```
HL7 Format:  YYYY[MM[DD[HHMM[SS[.S[S[S[S]]]]]]][+/-ZZZZ]
EXAMPLE
   |200302171830|
```

Definition: This field contains the date/time that the sending system created the message. Local time is expected, but, if the time zone is specified, it will be used throughout the message as the default time zone. Precision to the minute level is acceptable for the purpose of this message and time zone is not required.

Message type (CM) 00009

```
Components:  <message type (ID)> ^ <trigger event (ID)> ^ <message structure (ID)>
```

Definition: This field contains the message type, trigger event, and abstract message structure code for the message. The first component is the message type edited by *HL7 table 0076 - Message type*; second is the trigger event code edited by *HL7 table 0003 - Event type*; third is the abstract message structure code edited by *HL7 Table 0354 - Message structure*.

For Hospital Syndromic Surveillance all messages will be of type ADT and trigger events will be A01, A04, or A08. Message structure will not be used.

|ADT^A04|

Processing ID (PT) 00011

```
Components:  <processing ID (ID)> ^ <processing mode (ID)>
EXAMPLE
|P|
```

Definition: This field is used to decide whether to process the message as defined in HL7 Application (level 7) Processing rules, above. The first component defines whether the message is part of a production, training, or debugging system (refer to *HL7 table 0103 - Processing ID* for valid values). The second component defines whether the message is part of an archival process or an initial load (refer to *HL7 table 0207 - Processing mode* for valid values). This allows different priorities to be given to different processing modes.

Most messages for Hospital Syndromic Surveillance will be Production messages. Other values will only be accepted for the purposes of initial testing, debugging, or archival data as instructed by MODHSS.

Table 0103 - Processing ID

Value	Description
D	Debugging
P	Production
T	Training

Table 0207 - Processing mode

Value	Description
A	Archive
R	Restore from archive
I	Initial load
not present	Not present (the default, meaning *current* processing)

Version ID (VID) 00012

```
Components:  <version ID (ID)> ^ <internationalization code (CE)> ^ <internal
          version ID (CE)>

EXAMPLE

    |2.3.1|
```

Definition: This field is matched by the receiving system to its own version to be sure the message will be interpreted correctly. Preferred version is 2.3.1.

Table 0104 - Version ID

Value	Description	
2.0	Release 2.0	September 1988
2.0D	Demo 2.0	October 1988
2.1	Release 2. 1	March 1990
2.2	Release 2.2	December 1994
2.3	Release 2.3	March 1997
2.3.1	Release 2.3.1	

19 CSR 10-33.040 HESS HL7 Exhibit A

1.0 PID Segment – Patient Identification

The PID segment is used as the primary means of communicating patient identification information. This segment contains permanent patient identifying and demographic information that is not likely to change frequently.

PID Attributes

SEQ	LEN	DT	OPT	TBL#	RP/#	ITEM#	Element Name
1	4	SI	R			00104	Set ID - Patient ID
2	20	CX	O			00105	Patient ID (External ID)
3	20	CX	R		Y	00106	Patient ID (Internal ID)
4	20	CX	O		Y	00107	Alternate Patient ID - PID
5	48	XPN	R			00108	Patient Name
6	48	XPN	O			00109	Mother's Maiden Name
7	26	TS	R			00110	Date/Time of Birth
8	1	IS	R	0001		00111	Sex
9	48	XPN	O		Y	00112	Patient Alias
10	1	IS	R	0005		00113	Race
11	106	XAD	R		Y	00114	Patient Address
12	4	IS	O			00115	County Code
13	40	XTN	R		Y	00116	Phone Number - Home
14	40	XTN	O		Y	00117	Phone Number - Business
15	60	CE	O	0296		00118	Primary Language
16	1	IS	O	0002		00119	Marital Status
17	3	IS	O	0006		00120	Religion
18	20	CX	O			00121	Patient Account Number
19	16	ST	R			00122	SSN Number - Patient
20	25	CM	O			00123	Driver's License Number - Patient
21	20	CX	O		Y	00124	Mother's Identifier
22	3	IS	R	0189		00125	Ethnic Group
23	60	ST	O			00126	Birth Place
24	2	ID	O	0136		00127	Multiple Birth Indicator
25	2	NM	O			00128	Birth Order
26	4	IS	O	0171	Y	00129	Citizenship
27	60	CE	O	0172		00130	Veterans Military Status
28	80	CE	O			00739	Nationality
29	26	TS	O			00740	Patient Death Date and Time
30	1	ID	R	0136		00741	Patient Death Indicator

Example Segment of PID

PID|1||9510110000l^^^^^ MO Hospital&013319934&NPI ||Doe^John^Q^Jr||19641004|M||W|2166 Wells Drat B^Jefferson City^MO^65101^USA^^^Cole||^^^^206^6793240||||||423523049|||N|||||||N|<cr>

PID-1 Set ID-patient ID (SI)
This field allows for multiple PID segments (i.e. multiple patient reports) with a single MSH. The Set ID field is used to identify repetitions. For hospital-based reporting, it is strongly recommended that information for only one patient be sent per message, in other words, one PID per MSH. Thus, PID-1 may be left blank or should appear as:

|1|

PID-3 Patient ID (internal ID) (CX)
PID-3 is essentially the patient identifier (i.e., medical record number) from the hospital, which is submitting the report to public health officials. The field has the same components as PID-2:

<ID (ST)> ^ <check digit (ST)> ^ <code identifying the check digit scheme employed (ID)> ^ <assigning authority (HD)> ^ <identifier type code (IS)> ^ <assigning facility (HD)>

The <assigning facility> is a component of PID-2, and thus is separated from the other components by a "^". The component <assigning facility> has three subcomponents which are separated with a "&". Since HL7 allows users to define the subcomponents of the HD data type, the <assigning facility> has the following definition for the hospital-based reporting message:

namespace ID	Name of originating hospital
universal ID	Unique NPI number of originating hospital
universal ID type	"NPI"

Repeating Identifiers
Repeating Identifiers are used when there is a need to represent multiple internal identifiers used at an institution. The field would appear as:

|95101100001^^^^MO Hospital&013319934&NPI|~|56850125M7^^^^MO Hospital&013319934&NPI|

PID-5 Patient Name (XPN)
Field has the following components:

<family name (ST)> ^ <given name (ST)> ^ <middle initial or name (ST)> ^ <suffix (e.g., JR or III) (ST)> ^ <prefix (e.g., DR) (ST)> ^ <degree (e.g., MD) (ST)> ^ <name type code (ID)>

For example:

|Doe^John^Q^Jr|

PID-7 Date/Time of Birth (TS)
The field has the same structure as defined for MSH-7. The field should contain at least the year, month, and date. For example:

|19641004|

If the patient's age only is available, HL7 2.3 allows the degree of precision to be changed so that only the year is provided:

|1964|

PID-8 Sex (IS)
HL7 allows users to define the values for Table 0001. The accepted values for the hospital-based reporting message are:

Sex - Table 0001

Value	Description
F	Female
M	Male
U	Unknown / not stated

For example:

|M|

PID-10 Race (IS)
HL7 allows users to define the values for Table 0005. The values below are recommended for the hospital-based reporting message:

Race - Table 0005

Value	Description
W	White
B	Black
A	Asian or Pacific Islander
I	American Indian or Alaskan Native
M	Multiracial
O	Other
U	Unknown

For example:

|W|

If possible, "M" (multiracial) should be indicated as repeating values using the repetition character "~".

Example: |M|~|W|~|I|

PID-11 Patient Address (XAD)
This field contains the mailing address of the patient. This information is of great importance to agencies receiving reports. The information allows health officials to notify local agencies of potential public health problems in their jurisdictions.

Multiple addresses for the same person may be sent (using the repetition character "~") in the following sequence: the primary mailing address must be sent first in the sequence; if the primary mailing address is not sent then a repeat delimiter must be sent in the first sequence. The field has the following components:

<street address (ST)> ^ < other designation (ST)> ^ <city (ST)> ^ <state or province (ST)> ^ <zip or postal code (ST)> ^ <country (ID)> ^ <address type (ID)> ^ <other geographic designation (ST)> ^ <county/parish code (IS)> ^ <census tract (IS)>

For example:

|2166 Wells Dr^Apt B^Jefferson City^MO^65101^USA^^Cole|

PID-13 Phone Number - Home (XTN)
Field will follow the HL7-defined structure for extended telecommunications number, data type XTN, which has the following components:

[NNN] [(999)]999-9999 [X99999] [B99999] [C any text] ^ <telecommunication use code (ID)> ^ <telecommunication equipment type (ID)> ^ <E-mail address (ST)> ^ <country code (NM)> ^ <area/city code (NM)> ^ <phone number (NM)> ^ <extension (NM)> ^ <any text (ST)>

Components five through nine reiterate the basic function of the first component in a delimited form that allows the expression of both local and international telephone numbers. In HL7 Version 2.3, the recommended form for the telephone number is to use the delimited form rather than the unstructured form supported by the first component (which is left in for backward compatibility only). Alternative home phone numbers can be provided with the repeating character "~".

For example:

|^^^^206^6793240^^call after 5:00 pm only ~ ^^^^206^6795772|

PID-14 Phone Number - Business (XTN)
Field will follow the HL7-defined structure for extended telecommunications number (XTN) as described in PID-13.

PID-19 Social Security Number (SSN) (ST)
This field contains the patient's social security number. The field should contain the 9 digit SSN without hyphens or spaces.

For example:

|423523049|

PID-22 Ethnic Group (IS)
The following table should be used for hospital-based reporting if the ethnic group of the patient is known:

Ethnic Group - Table 0189

Value	Description
H	Hispanic
N	Non-Hispanic
U	Unknown

For example:

|N|

PID-29 Patient death date and time (TS)
Field is optional for HL7 2.3 but is recommended for hosptial-based reporting if available.

PID-30 Patient death indicator (ID)
Field is optional for HL7 2.3 but is recommended for hospital-based reporting if available. HL7 requires the use of *HL7 table 0136 - Yes/No Indicator* for PID-30 where Y=yes and N=no.

An example for a patient that died is:

|Y|

19 CSR 10-33.040 HESS HL7 Exhibit A

PV1 Segment – Patient visit segment

The PV1 segment is used by Registration/Patient Administration applications to communicate information on a visit-specific basis.

SEQ	LEN	DT	OPT	RP/#	TBL#	ITEM#	ELEMENT NAME
1	4	SI	O			00131	Set ID - PV1
2	1	IS	R		0004	00132	Patient Class
3	80	PL	O			00133	Assigned Patient Location
4	2	IS	R		0007	00134	Admission Type
5	20	CX	O			00135	Preadmit Number
6	80	PL	O			00136	Prior Patient Location
7	60	XCN	O	Y	0010	00137	Attending Doctor
8	60	XCN	O	Y	0010	00138	Referring Doctor
9	60	XCN	O	Y	0010	00139	Consulting Doctor
10	3	IS	O		0069	00140	Hospital Service
11	80	PL	O			00141	Temporary Location
12	2	IS	O		0087	00142	Preadmit Test Indicator
13	2	IS	O		0092	00143	Re-admission Indicator
14	3	IS	R		0023	00144	Admit Source
15	2	IS	O	Y	0009	00145	Ambulatory Status
16	2	IS	O		0099	00146	VIP Indicator
17	60	XCN	O	Y	0010	00147	Admitting Doctor
18	2	IS	O		0018	00148	Patient Type
19	20	CX	R			00149	Visit Number
20	50	FC	O	Y	0064	00150	Financial Class
21	2	IS	O		0032	00151	Charge Price Indicator
22	2	IS	O		0045	00152	Courtesy Code
23	2	IS	O		0046	00153	Credit Rating
24	2	IS	O	Y	0044	00154	Contract Code
25	8	DT	O	Y		00155	Contract Effective Date
26	12	NM	O	Y		00156	Contract Amount
27	3	NM	O	Y		00157	Contract Period
28	2	IS	O		0073	00158	Interest Code
29	1	IS	O		0110	00159	Transfer to Bad Debt Code
30	8	DT	O			00160	Transfer to Bad Debt Date
31	10	IS	O		0021	00161	Bad Debt Agency Code
32	12	NM	O			00162	Bad Debt Transfer Amount
33	12	NM	O			00163	Bad Debt Recovery Amount
34	1	IS	O		0111	00164	Delete Account Indicator
35	8	DT	O			00165	Delete Account Date
36	3	IS	O		0112	00166	Discharge Disposition
37	25	CM	O		0113	00167	Discharged to Location
38	80	CE	O		0114	00168	Diet Type
39	2	IS	O		0115	00169	Servicing Facility
40	1	IS	O		0116	00170	Bed Status
41	2	IS	O		0117	00171	Account Status
42	80	PL	O			00172	Pending Location
43	80	PL	O			00173	Prior Temporary Location
44	26	TS	R			00174	Admit Date/Time

SEQ	LEN	DT	OPT	RP/#	TBL#	ITEM#	ELEMENT NAME
45	26	TS	O			00175	Discharge Date/Time
46	12	NM	O			00176	Current Patient Balance
47	12	NM	O			00177	Total Charges
48	12	NM	O			00178	Total Adjustments
49	12	NM	O			00179	Total Payments
50	20	CX	O		0203	00180	Alternate Visit ID
51	1	IS	O		0326	01226	Visit Indicator
52	60	XCN	O	Y	0010	01274	Other Healthcare Provider

Example

PV1|1|E||E|||||||||7||||8399193^^^MO Hospital&013319934&NPI|||||||||||||||||||||033120031420<cr>

Set ID - PV1 (SI) 00131

Definition: This field contains the number that identifies this transaction. For the first occurrence of the segment, the sequence number shall be one, for the second occurrence, the sequence number shall be two, etc.

Patient class (IS) 00132

Definition: This field is used by systems to categorize patients by site. It does not have a consistent industry-wide definition. It is subject to site-specific variations. Refer to *user-defined table 0004 - Patient class* for suggested values.

User-defined Table 0004 - Patient class

Value	Description
E	Emergency
I	Inpatient
O	Outpatient
P	Preadmit
R	Recurring Patient
B	Obstetrics

Admission type (IS) 00134

Definition: This field indicates the circumstances under which the patient was or will be admitted. Refer to *user-defined Table 0007 - Admission type* for suggested values.

User-defined Table 0007 - Admission type

Value	Description
A	Accident
E	Emergency
L	Labor and Delivery
R	Routine

Admit source (IS) 00144

Definition: This field indicates where the patient was admitted. Refer to *user-defined table 0023 - Admit source* for suggested values. This field is used on UB92 FL19. The UB codes listed, as examples are not an exhaustive or current list; refer to a UB specification for additional information.

Note: The official title of UB is "National Uniform Billing Data Element Specifications." Most of the codes added came from the UB-92 specification, but some came from the UB-82.

User-defined Table 0023 - Admit source

Value	Description
1	Physician Referral
2	Clinic Referral
3	HMO Referral
4	Transfer from a Hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available

Visit number (CX) 00149

```
Components:  <ID (ST)> ^ <check digit (ST)> ^ <code identifying the check
          digit scheme employed (ID)> ^ <assigning authority (HD)> ^
          <identifier type code (IS)> ^ <assigning facility (HD)>

Subcomponents of assigning authority:  <namespace ID (IS)> & <universal ID
          (ST)> & <universal ID type (ID)>

Subcomponents of assigning facility:   <namespace ID (IS)> & <universal ID
          (ST)> & <universal ID type (ID)>
```

Definition: ***For backward compatibility***, an NM data type may be sent, but HL7 recommends that new implementations use the CX data type. This field contains the unique number assigned to each patient visit. The assigning authority and identifier type code are strongly recommended for all CX data types.

Admit date/time (TS) 00174

Definition: This field contains the admit date/time. It is to be used if the event date/time is different than the admit date and time, i.e., a retroactive update. This field is also used to reflect the date/time of an outpatient/emergency patient registration.

19 CSR 10-33.040 HESS HL7 Exhibit A

PV2 Segment – Patient visit – additional information segment

In order to leverage data available in existing clinical information system, chief complaint data will be sent in a ***PV2*** segment ***Admit Reason*** element. This element is a CE data type but should be sent as free text. The location or institution and date/time would be inferred from the ***MSH*** segment.

The ***PV2*** segment description in this implementation guide is IDENTICAL to the HL7 V2.3.1 ***PV2*** description in Chapter 3 except that the ***Admit Reason*** element is required and the discussion of this element has been expanded.

PV2 attributes

SEQ	LEN	DT	OPT	RP/#	TBL#	ITEM#	ELEMENT NAME
1	80	PL	C			00181	Prior Pending Location
2	60	CE	O		0129	00182	Accommodation Code
3	60	CE	R			00183	Admit Reason
4	60	CE	O			00184	Transfer Reason
5	25	ST	O	Y		00185	Patient Valuables
6	25	ST	O			00186	Patient Valuables Location
7	2	IS	O		0130	00187	Visit User Code
8	26	TS	O			00188	Expected Admit Date/Time
9	26	TS	O			00189	Expected Discharge Date/Time
10	3	NM	O			00711	Estimated Length of Inpatient Stay
11	3	NM	O			00712	Actual Length of Inpatient Stay
12	50	ST	O			00713	Visit Description
13	90	XCN	O	Y		00714	Referral Source Code
14	8	DT	O			00715	Previous Service Date
15	1	ID	O		0136	00716	Employment Illness Related Indicator
16	1	IS	O		0213	00717	Purge Status Code
17	8	DT	O			00718	Purge Status Date
18	2	IS	O		0214	00719	Special Program Code
19	1	ID	O		0136	00720	Retention Indicator
20	1	NM	O			00721	Expected Number of Insurance Plans
21	1	IS	O		0215	00722	Visit Publicity Code
22	1	ID	O		0136	00723	Visit Protection Indicator
23	90	XON	O	Y		00724	Clinic Organization Name
24	2	IS	O		0216	00725	Patient Status Code
25	1	IS	O		0217	00726	Visit Priority Code
26	8	DT	O			00727	Previous Treatment Date
27	2	IS	O		0112	00728	Expected Discharge Disposition
28	8	DT	O			00729	Signature on File Date
29	8	DT	O			00730	First Similar Illness Date
30	80	CE	O		0218	00731	Patient Charge Adjustment Code
31	2	IS	O		0219	00732	Recurring Service Code
32	1	ID	O		0136	00733	Billing Media Code
33	26	TS	O			00734	Expected Surgery Date & Time
34	1	ID	O		0136	00735	Military Partnership Code
35	1	ID	O		0136	00736	Military Non-Availability Code
36	1	ID	O		0136	00737	Newborn Baby Indicator
37	1	ID	O		0136	00738	Baby Detained Indicator

Example PV2 Segment
PV2|||789.00^ABDMNAL PAIN UNSPCF SITE^I9C<cr>
PV2|||^STOMACH ACHE<cr>

Admit reason (CE) 00183

```
Components:  <identifier (ST)> ^ <text (ST)> ^ <name of coding
             system (ST)> ^ <alternate identifier (ST)> ^ <alternate
             text (ST)> ^ <name of alternate coding system (ST)>
```

Definition: This field contains a short description of the reason for patient's visit. This reason may be coded as ICD-9-CM or ICD-10 codes but will often be sent as free text. If the reason is sent as a coded value, the text component must be sent in order to allow systems, which rely on text to operate without having access to tables of coding systems that include text descriptions.

Complete Message Example

MSH|^~\&||MO Hospital^013319934^NPI|MOHESS|MODHSS|200302171830||ADT^A04||P|2.3.1<cr>
PID|1||95101100001^^^^MO Hospital&013319934&NPI||Doe^John^Q^Jr||19641004|M||W|2166 Wells Dr^Apt B^Jefferson City^MO^65101^USA^^^Cole||^^^^206^6793240|||M|||423523049|||N<cr>
PV1|1|E||E|||||||||7|||||||8399193^^^MO Hospital&013319934&NPI|||||||||||||||||||200302171420<cr>
PV2|||789.00^ABDMNAL PAIN UNSPCF SITE^I9C<cr>

19 CSR 10-33.040 HESS Structure File Exhibit B

As an alternative for hospitals that are not able to support HL7 messages, the following format will be used for transmission of data. The structure closely follows the fields defined in the HL7 message format.

All fields will be left justified with unknown values padded with spaces. Each record should end with a carriage return (ASC13) or carriage return/line feed (ASC13 ASC10).

The required column in Table 1 indicates whether a field is Required (R), Optional (O) or Conditionally (C) required. See the description to determine the requirements for conditional fields.

Table 1 – Hospital Syndromic Surveillance ASCII file structure

Field Name	Relative Position	Field Length	Required	Format	Description
Record Type	1	1	R	A	4 – New Record 8 = Update of previously sent record
Sending Facility Identifier	2-11	10	R	A/N	This field shall contain the National Provider Identifier (NPI) for the hospital/facility sending data. If no NPI is available, use the Medicare provider number of state assigned number.
Sending Facility Name	12-41	30	R	A/N	Name of the originating hospital
Date/Time of Message	42-53	12	R	N	YYYYMMDDHHMM format for date and time record or message set is generated.
Processing ID	54	1	R	A	Unless directed by DHSS, all records should be Production records "P" P – Production D = Debugging/Testing.
Patient Medical Record Number	55-74	20	R	A/N	Medical Record Number of the patient.
Patient Last Name	75-104	30	R	A/N	Last name of patient. No space should be embedded within a last name as in MacBeth. Titles (for example, Sir, Msgr., Dr.) should not be recorded. Record hyphenated names with the hyphen, as in Smith-Jones.
Patient First Name	105-124	20	R	A/N	First name of patient.
Patient Middle Name	125-144	20	O	A/N	Middle name or initial of patient, if known.
Patient Name Suffix	145-150	6	O	A/N	Record suffixes such as JR, SR, III, if known
Date of Birth	151-158	8	R	N	YYYYMMDD date of birth. If only age is known, record YYYY as year of birth.
Sex	159	1	R	A	Patient sex at time of encounter M – Male F = Female U = Unknown

19 CSR 10-33.040 HESS Structure File Exhibit B

Field Name	Relative Position	Field Length	Required	Format	Description
Race	160	1	R	A	W = White B = Black or African American A = Asian or Pacific Islander I = American Indian or Alaska Native M = Multiracial (two or more races) O = Other U = Unknown
Ethnicity	161	1	R	A	H = Hispanic or Latino N = Not Hispanic or Latino U = Unknown
Residence Address Line 1	162-191	30	R	A/N	Free form address line
Residence Address Line 2	192-221	30	C	A/N	Free form address line, if needed.
City	222-246	25	R	A/N	Patient city of residence.
State	247-248	2	R	A/N	Postal abbreviation for state of residence. Use 97 for homeless, 98 for non-US.
Zip Code	249-253	5	R	N	First five digits (homeless – 99997, non-US = 99998)
County Code	254-256	3	R	N	Use FIPS codes (homeless = 997, non-US = 998)
Country Code	257-260	4	R	N	Use FIPS codes (homeless - 9997)
Phone Number Area Code	261-263	3	O	N	Format 999 if known, blank if not known
Phone Number	264-271	8	O	A/N	Format 999-9999 including hyphen if known, blank if not known.
Extension	272-276	5	O	A/N	Telephone extension, if necessary or known.
Social Security Number	277-285	9	R	N	Contains the 9-digit SSN without hyphens or spaces
Patient Death Indicator	286	1	O	A	If available. Y = Yes N = No
Patient Death Date Time	287-298	12	C	N	YYYYMMDDHHMM representation of Date and Time (if known) of death if indicator is "Y".
Patient Class	299	1	R	A	Used to categorize patients by site. E = Emergency I = Inpatient O = Outpatient P = Preadmit R = Recurring patient B = Obstetrics
Admission Type	300	1	R	A	Indicates the circumstances under which the patient was or will be admitted A = Accident E = Emergency L = Labor and delivery R = Routine
Unique Encounter Identifier	301-320	20	R	A/N	Unique identifier within facility for each patient encounter or visit.

19 CSR 10-33.040 HESS Structure File Exhibit B

Field Name	Relative Position	Field Length	Required	Format	Description
Admit Date/Time	321-342	12	R	N	YYYYMMDDHHMM This field contains the admit date and time. This field is also used to reflect the date/time of an emergency patient or outpatient registration
Admit Reason Text	343-462	120	R	A/N	Textual literal chief complaint. The text must be sent even if a code is available.
Admit Reason Code	463-472	10	O	A/N	Diagnostic code for the reason for visit or chief complaint, if available. Not all hospitals will have this code available at the time of the initial report to DHSS.
Admit Reason Coding Scheme	473-480	8	C	A/N	Standardized Coding scheme used for the Admit Reason Code, if used. I9C = ICD-9-CM I10 = ICD-10 SNOMED = SNOMED
Filler	481-500	20	R		Spaces

AUTHORITY: sections 192.020, 192.067 and 192.667, RSMo 2000. Emergency rule filed June 25, 2003, effective July 6, 2003, expired Jan. 2, 2004. Original rule filed June 25, 2003, effective Dec. 30, 2003.*

**Original authority: 192.020, RSMo 1939, amended 1945, 1951; 192.067, RSMo 1988; and 192.667, RSMo 1992, amended 1993, 1995.*

19 CSR 10-33.050 Reporting of Healthcare-Associated Infection Rates by Hospitals and Ambulatory Surgical Centers

PURPOSE: This rule establishes procedures for reporting hospital and ambulatory surgical center healthcare-associated infection incidence data to the Department of Health and Senior Services.

(1) The following definitions shall be used in the interpretation of this rule:

(A) CDC means the federal Centers for Disease Control and Prevention;

(B) Central line as defined by the CDC;

(C) Central line-associated bloodstream (CLAB) infection as defined by the CDC means central line-related bloodstream infection as referred to in section 192.667.12(3), RSMo;

(D) Department means the Missouri Department of Health and Senior Services;

(E) Healthcare provider means hospitals as defined in section 197.020, RSMo, and ambulatory surgical centers (ASCs) as defined in section 197.200, RSMo;

(F) Intensive care unit (ICU) means coronary, medical, surgical, medical/surgical, pediatric, and neonatal intensive care units (NICU);

(G) National Healthcare Safety Network (NHSN) means the CDC nosocomial infection surveillance system;

(H) Neonatal Intensive Care Unit (NICU) and High Risk Nursery (HRN) are synonymous and mean that the infants in those units are critically ill and receive level III care as defined by the CDC;

(I) Nosocomial infection is defined in section 192.665(6), RSMo and is referred to as healthcare-associated infection (HAI) in this rule;

(J) Risk index means grouping patients who have operations according to the American Society of Anesthesiologists (ASA) score, length of procedure, wound class, and other criteria as defined by the CDC for the purpose of risk adjustment as required in section 192.667.3, RSMo;

(K) Surgical site infection (SSI) as defined by the CDC; and

(L) Ventilator-associated pneumonia (VAP) as defined by the CDC.

(2) All hospitals shall submit to the department data to compute HAI infection incidence rates on the following:

(A) CLABs detected in the ICU(s) after June 30, 2005;

(B) SSIs from designated types of surgeries as set forth in section (4) of this rule, performed after December 31, 2005; and

(C) VAPs in the ICU(s) detected after June 30, 2006.

(3) All ASCs shall submit to the department data to compute HAI incidence rates on SSIs from designated types of surgeries as set forth in section (5) of this rule, performed after December 31, 2005.

(4) Hospitals shall report SSIs by risk index related to a hip prosthesis, to an abdominal hysterectomy, and to a coronary artery bypass graft with both chest and donor site incisions performed after December 31, 2005.

(5) ASCs shall report SSIs by risk index related to breast surgery and herniorrhaphy performed after December 31, 2005.

(6) In order to be eligible to request a reporting exemption, healthcare providers shall report to the department by March 1, 2005, and every year thereafter the number of central line days and ventilator days in the ICU(s) during the previous calendar year; and the number of surgeries performed as required in sections (4) and (5) during the previous calendar year.

(A) Healthcare providers that had less than fifty (50) central line days in any ICU shall be exempt from reporting CLABs from that ICU for the reporting year starting in July.

(B) Healthcare providers that had less than fifty (50) ventilator days in any ICU shall be exempt from reporting VAPs from that ICU for the reporting year starting in July.

(C) Healthcare providers that had less than twenty (20) surgeries as specified in sections (4) and (5) shall be exempt from reporting the surgery that did not meet the minimum for the reporting year starting in July.

(D) The exemptions shall only apply if the healthcare provider has an infection control program that is in compliance with applicable statutes and regulations of the health facilities regulation unit of the department. The department shall notify the healthcare provider in writing if such provider is exempt from any reporting requirements for the reporting year starting in July.

(7) Healthcare providers may meet the HAI reporting requirements if they submit their data to the CDC NHSN or its successor system and if:

(A) All NHSN mandatory data items are submitted to the CDC;

(B) The healthcare provider complies with all NHSN standards and procedures;

(C) The healthcare provider participates in NHSN training provided by the CDC;

(D) The healthcare provider has policies and procedures to ensure that all HAIs as required by this rule are detected and reported. Such policies and procedures shall be consistent with appropriate guidelines of CDC, or the Society for Healthcare Epidemiology of America (SHEA), or the Association for Professionals in Infection Control and Epidemiology (APIC);

(E) The healthcare provider has a process to follow up for SSIs a minimum of thirty (30) days after the procedure was performed, and at a minimum review readmission data to identify potential SSIs. Hospitals shall have a system for reporting identified SSIs to the healthcare provider performing the original surgery;

(F) All data are submitted to the NHSN within sixty (60) days of the end of the month;

(G) The healthcare provider participates in a CDC user group that allows the department access to the data, or a data file is generated by the healthcare provider and submitted to the department; and

(H) The healthcare provider shall maintain records related to the information provided to the department for a minimum of two (2) years.

(8) If a healthcare provider chooses to not submit the required data to the CDC NHSN, the healthcare provider may meet the HAI reporting requirements by submitting to the department numerator and denominator data on forms provided by the department, or in a format approved by the department, for each of the infections specified in sections (2), (3), (4), and (5) and if:

(A) The healthcare provider complies with all NHSN standards and procedures;

(B) The healthcare provider participates in NHSN training provided by the CDC;

(C) The healthcare provider has policies and procedures to ensure that all HAIs as required by this rule are detected and reported. Such policies and procedures shall be consistent with appropriate guidelines of CDC, or the SHEA, or the APIC;

(D) The healthcare provider has a process to follow up for SSIs a minimum of thirty (30) days after the procedure was performed,

and at a minimum review readmission data to identify potential SSIs. Hospitals shall have a system for reporting identified SSIs to the healthcare provider performing the original surgery;

(E) All data are submitted to the department within sixty (60) days of the end of the month; and

(F) The healthcare provider shall maintain records related to the information provided to the department for a minimum of two (2) years.

(9) The healthcare provider chief executive officer or designee shall annually certify in writing to the department, on a form provided by the department, that the healthcare provider has met all conditions specified in this rule.

AUTHORITY: section 192.667, RSMo Supp. 2004. Original rule filed Feb. 1, 2005, effective July 30, 2005.*

**Original authority: 192.667, RSMo 1992, amended 1993, 1995, 2004.*