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MATT BLUNT

SECRETARY OF STATE

MISSOURI REGISTER

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FROM THIS ANGLE . . . .

Good news!!!

The Administrative Rules Division is pleased to advise that on or about April 15, 2001, we will be able to offer Master Card/Visa as an alternative form of payment for subscriptions, copying charges, charges for certification, etc. We hope this will enable you, our customer, to obtain quicker access to the materials and information you seek.

Bracketed and Bolded Text

Because of confusion by many state agencies, we have once again revisited this topic with our General Counsel and with the hope of clarifying any existing confusion. Therefore, for clarification purposes, the recommended procedure by the Administrative Rules Division for publishing in ***final orders of rulemaking*** is to **exclude** any bracketed and bolded text.

Incorporated by Reference/Included Herein (Forms)

This topic, also, has created a great amount of confusion – not only by agencies but within our own staff, as well. It has been "revisited" because several agencies have made the determination to remove forms from their rules. To clarify: Our policy on this subject will now be:

When we **do** include the form, we will state in the text of the rule that the form is "***included herein***."

When the form is **not** published but is considered part of the rule, the form will be referred to as "***incorporated by reference***" in the text of the rule.

It is our hope that this editorial change will help simplify matters for the agencies, as well as the readers.

Finally, we need your help!!

It is the goal of the Administrative Rules Division to undertake a total rewrite of our rulemaking manual, more commonly known as, **Guide to Administrative Rulemaking**, and, once that project is completed, we will again offer training classes on the rulemaking process. In order to assist us in accomplishing this goal, we need your help and input. We are in the process of forming a users/focus group and would appreciate your *volunteer* participation – either in person or, alternatively, by writing us and informing us about your concerns, suggestions, complaints, unique problems or ideas. We feel that those of you who are "out there in the trenches" writing the rules are

more familiar with the problems, questions, complaints, and/or possible solutions than we may be!

Please **write, call** (573-751-4015), **e-mail** (rulesa@sosmail.state.mo.us) **or** **fax** us (573-751-3032) and offer your participation in this process. Within two weeks, we plan to establish a meeting date, compile a users/focus group roster, and advise of our first session date. We would greatly appreciate your participation and look forward to the opportunity to work with you as together we strive to improve the rulemaking process! Some of you have already willingly offered to participate, for which we thank you – please ***sign up today*** – we need and want your help! Together, we can make this process much more "user friendly."

As the new Director of the Administrative Rules Division, I look forward to working with each of you and assisting you in the process of publishing your rules. If we may ever be of assistance to you in any way, please do not hesitate to contact us. We believe it is our job to help you – and we want to make your process as painless as possible. Please stop by my office and introduce yourself the next time you are in the division to file your rules. I look forward to working together.

Lynne C. Angle
Director

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Aug. 31, 2001	**Oct. 1, 2001**	Oct. 31, 2001	Nov. 30, 2001
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Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule.

Missouri Depository Libraries

The *Missouri Register* and the *Code of State Regulations*, as required by the Missouri Depository Documents Law (section 181.100, RSMo 2000), are available in the listed depository libraries, as selected by the Missouri State Library:

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HOW TO CITE RULES AND RSMo

RULES—Cite material in the *Missouri Register* by volume and page number, for example, Vol. 26, *Missouri Register*, page 27. The approved short form of citation is 26 MoReg 27.

The rules are codified in the *Code of State Regulations* in this system—

Title	*Code of State Regulations*	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—Cite material in the RSMo by date of legislative action. The note in parentheses gives the original and amended legislative history. The Office of the Revisor of Statutes recognizes that this practice gives users a concise legislative history.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons and findings which support its conclusion that there is an immediate danger to the public health, safety or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than 180 calendar days or 30 legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 19—DEPARTMENT OF HEALTH
Division 10—Office of the Director
Chapter 33—Hospital and Ambulatory Surgical Center Data Disclosure

EMERGENCY AMENDMENT

19 CSR 10-33.010 Reporting Patient Abstract Data by Hospitals and Ambulatory Surgical Centers. The department proposes to amend this rule by amending section (4), subsection (B); section (8); and replacing Exhibit B.

PURPOSE: This amendment is to make the patient abstract data reporting requirements consistent with provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as they relate to standards for health data transactions, and to improve the capacity of the department to provide analyses and statistical information on community health assessments and public health topics.

EMERGENCY STATEMENT: This emergency amendment is necessary to obtain patient abstract data that are consistent with current public health data standards. The Missouri Department of Health has the responsibility to collect patient abstract data from hospitals and ambulatory surgery centers, as mandated in section 192.667, RSMo 2000. These data are used by the Department for epidemiological studies, community health assessments, consumer reports, and for monitoring the delivery of health care in Missouri. The deliverable date for submission of the first quarter of 2001 patient abstract data to the Department is on or before September 1, 2001. To allow sufficient time for providers to make the necessary programming and data revisions, providers need immediate notice of the changes to the data requirements. As such, the Department finds a compelling government interest, which requires emergency action. The scope of this rule amendment is limited to the circumstances creating the emergency and complies with the protections extended in the ***Missouri*** *and* ***United States Constitutions****. The Department of Health believes this emergency rule amendment is fair to all interested parties under the circumstances. This emergency rule amendment was filed on March 1, 2001, effective April 1, 2001 and expires January 10, 2002.*

(4) The patient abstract data shall include the data elements and conform to the specifications listed in Exhibit B of this rule**, included herein,** and shall be submitted on *[magnetic]* **electronic** media. Acceptable *[magnetic]* **electronic** media include the following:

(B) *[Floppy disk (MS-DOS/PC-DOS compatible). Three and one-half-inch (3 1/2") eighty (80) tracks per side, eighteen (18) sectors per track, double-sided (1.44 Mb). Shall be on media rated at least 135 tpi with 2.0 Mb total rating]* **IBM formatted 1.44 Mb diskette**; or

(8) The department shall 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 *[magnetic]* **electronic** media. The department shall make the reports and data available for a reasonable charge based on incurred costs.

AUTHORITY: section 192.667, RSMo [Supp. 1997] ***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. Changed from 19 CSR 30-33.010, effective Aug. 1, 1996. Amended: Filed May 15, 1998, effective Nov. 30, 1998. Emergency amendment filed March 1, 2001, effective April 1, 2001, expires Jan. 10, 2002.*

EXHIBIT B
Patient Abstract System
A-Record
(Master Record)

Field Name	Relative Position	Field Length	Format	Justify	Description
Record type	1	1	A	L	Constant "A"
Provider identifier	2-11	10	A/N	L	This field shall contain the National Provider Identifier (NPI), when assigned. Prior to NPI assignment, enter the Medicare provider number (or state assigned number).
Unique encounter identifier	12-31	20	A/N	L	Unique identifier within facility (hospital or ASC) for each discharge record or patient encounter.
Type of encounter	32	1	N	L	Type of encounter record 1 = Inpatient; 2 = Outpatient.
Place of service	33	1	N	L	For hospital inpatients 1 = Acute medical/surgical unit (non PPS exempt); 2 = Psychiatric unit or facility; 3 = Medical rehabilitation unit or facility; 4 = Alternate level of care (SNF/ICF/Other LTC/ Hospice/Sub Acute/Swing bed); 5 = Alcohol rehabilitation unit or facility; 6 = Drug rehabilitation unit or facility; 7 = Other. For hospital outpatients 1 = Emergency room; 2 = Outpatient surgery; 3 = Observation only; 4 = Other. For ASC patients 2 = Outpatient surgery
Patient name	34-63	30	A/N	L	Not to be reported for patients receiving treatment for alcohol or drug abuse. Last name, first name and middle initial of the patient. Use a comma to separate last and first names. No space should be left between a prefix and a name as in MacBeth. Titles (for example, Sir, Msgr., Dr.) should not be recorded. Record hyphenated names with the hyphen, as in Smith-Jones, Rebecca. To record suffix, write the last name, leave a space and write the suffix, then write the first name as in Snyder III, Harold.
Patient Social Security Number	64-72	9	N	R	Not to be reported for patients receiving treatment for alcohol or drug abuse. If patient refuses, code as 999999999.
Patient birthdate	73-80	8	N	R	MMDDYYYY
Patient sex	81	1	A	L	Patient sex at time of admission or start of care: M = Male; F = Female; U = Unknown/indeterminate.
Patient ethnicity	82	1	N	L	1 = Hispanic or Latino 2 = Neither Hispanic nor Latino

Field Name	Relative Position	Field Length	Format	Justify	Description
Patient race	83	1	N	L	1 = White; 2 = Black or African American; 3 = American Indian/Alaska Native; 4 = Asian; 5 = Native Hawaiian/Pacific Islander; 6 = Some other race 7= Multi-racial (two or more races) 9 = Unknown or patient refused
State of residence	84-85	2	N	R	FIPS codes (homeless = 97; non-U.S. citizen = 98)
Zip code	86-90	5	N	R	First five digits (homeless = 99997; non-U.S. citizen = 99998)
County code	91-93	3	N	R	Required for Missouri residents. Use FIPS codes (homeless = 997; non-U.S. citizen = 998)
Census tract	94-100	7	A/N	L	Census Tract code: 7 characters, fomatted XXXX.XX (where X is a digit 0-9) If census tract is not available, provide patient address information on the C-Record.
Admission date	101-108	8	N	R	MMDDYYYY
Admission hour	109-110	2	N	R	Required for inpatient records only 00 = 12:00 -- 12:59 Midnight; 01 = 1:00 -- 1:59 02 = 2:00 -- 2:59 03 = 3:00 -- 3:59 04 = 4:00 -- 4:59 05 = 5:00 -- 5:59 06 = 6:00 -- 6:59 07 = 7:00 -- 7:59 08 = 8:00 -- 8:59 09 = 9:00 -- 9:59 10 = 10:00 -- 10:59 11 = 11:00 -- 11:59 12 = 12:00 -- 12:59 Noon; 13 = 1:00 -- 1:59 14 = 2:00 -- 2:59 15 = 3:00 -- 3:59 16 = 4:00 -- 4:59 17 = 5:00 -- 5:59 18 = 6:00 -- 6:59 19 = 7:00 -- 7:59 20 = 8:00 -- 8:59 21 = 9:00 -- 9:59 22 = 10:00 -- 10:59 23 = 11:00 -- 11:59 99 = Unknown
Type of admission	111	1	N	L	Required for inpatient records only 1=Emergency—The patient requires immediate intervention as a result of severe, life threatening or potentially disabling conditions; 2=Urgent/Elective—(UB-92 codes 2 and 3); 4=Newborn—Use of this code requires special source of admission codes for newborns.

Field Name	Relative Position	Field Length	Format	Justify	Description
Source of admission/referral	112	1	N	L	<u>Code Structure for Adult/Pediatric Patients:</u> 1 = Direct admission or referral (UB-92 codes, 1, 2 and 3). The patient was admitted to this facility or referred for services upon the recommendation of a physician, or the facility's clinic or outpatient department. For emergency room patients, includes self-referral; 2 – Transfer from other hospital (UB-92 CODE 4). The patient was transferred for services to this facility or referred from an acute-care facility; 3 = Transfer from long-term care facility (UB-92 codes to 5 and 6). The patient was transferred from or referred for services by an SNF or other long-term facility. 4 = Emergency room admission or referral (UB-92 code 7). The patient was admitted to this facility or referred for outpatient services through the emergency room. 8 = Other (UB-92 code 8); 9 = Unknown/Information not available <u>Code Structure for Newborns:</u> 1 = Normal birth - A baby delivered without complications; 2 = Premature birth -- A baby delivered with time or weight factors, or both, qualifying it for premature status; 3 = Sick baby - A baby delivered with medical complications other than those related to premature status; 4 = Extramural birth A newborn born in a non sterile environment; 9 =Information not available.
Discharge Date	113-120	8	N	R	MMDDYYYY
Discharge hour	121-122	2	N	R	Required for inpatient records only 00 = 12:00 – 12:59 Midnight; 01 = 1:00 -- 1:59 02 = 2:00 -- 2:59 03 = 3:00 -- 3:59 04 = 4:00 -- 4:59 05 = 5:00 -- 5:59 06 = 6:00 -- 6:59 07 = 7:00 -- 7:59 08 = 8:00 -- 8:59 09 = 9:00 -- 9:59 10 = 10:00 --10:59 11 = 11:00 --11:59 12 = 12:00 --12:59 Noon; 13 = 1:00 -- 1:59 14 = 2:00 -- 2:59 15 = 3:00 -- 3:59 16 – 4:00 -- 4:59 17 = 5:00 -- 5:59 18 = 6:00 -- 6:59 19 = 7:00 -- 7:59 20 = 8:00 -- 8:59 21 – 9:00 -- 9:59 22 = 10:00 --10:59 23 = 11:00 --11:59 99 = Unknown.
Observation units	123-125	3	N	R	The number of hours spent by a patient held for observation

Field Name	Relative Position	Field Length	Format	Justify	Description
Disposition of patient	126-127	2	N	R	Designation of the circumstances associated with the patient's discharge. 01 = Discharged to home or self-care (routine discharge); 02 = Discharged/transferred to another short-term general hospital for inpatient care; 03 = Discharged/transferred to skilled nursing facility (SNF); 04 = Discharged/transferred to an intermediate care facility (ICF); 05 = Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution; 06 = Discharged/transferred to home under care of organized home health service organization 07 = Left against medical advice or discontinued care; 08 =Discharged/transferred to home under care of a Home IV provider; 09 =Admitted as an inpatient to this hospital; 20 =Expired
Medical/Health record number	128-144	17	A/N	L	Number assigned to the patient's medical/health record by the provider
E-Code External cause of injury	145-149	5	A/N	L	The ICD-9-CM code for the external cause of injury, poisoning or adverse effect. If more than one E-Code, enter the first E-code, according to coding guidelines. Required when either the Principal diagnosis code or Other diagnosis code reported is in the range 800.00-999.99
Place of injury code	150-154	5	A/N	L	The ICD-9-CM code for the place of injury reported in the External cause of injury field. Use when External Cause of Injury E-Code is E850 - E869 or E880-E928. Only codes in range E849.0-E849.9 are valid.
Principal diagnosis code	155-159	5	A/N	L	ICD-9-CM code. (Note: An E-Code is invalid as a principal diagnosis.)
Other diagnosis codes	160-199	40 (8 X 5)	A/N	L	ICD-9-CM code. Include any additional E-Codes not reported in the E-code or Place of injury fields.
Procedure coding method used	200	1	N	L	4 = CPT-4 5 = HCPCS 9 = ICD-9-CM
Principal procedure code/date	201-215	15			
Code		(7)	A/N	L	ICD-9-CM code or CPT-4 code
Date		(8)	N		MMDDYYYY
Other procedure codes and dates	216-290	75 (5 X 15)			All significant procedures are to be reported
Code		(7)	A/N	L	First 7 positions of each 15 position field: The ICD-9-CM code (s) or CPT-4 code (s) for the secondary procedures
Date		(8)	N		Next 8 positions of each 15 position field: MMDDYYYY

Field Name	Relative Position	Field Length	Format	Justify	Description
Total charges	291-297	7	N	R	Total charges (those associated with revenue code 001) rounded to the nearest dollar
Expected sources of payment	298-306	9 (3 X 3)	N	L	Payment sources expected to pay for the hospitalization or the ambulatory service being recorded, with the primary payer listed first: 001 = Medicare, not managed care; 002 = Medicaid, not managed care; 003 = Other government, not managed care; 005 = Workers' Compensation, not managed care; 006 = Self pay; 007 = All commercial payers, not managed care; 008 = No charge; 010 = Other, not managed care; 101 = Medicare managed care; 102 = Medicaid managed care; 103 = Other government managed care; 105 = Workers' Compensation managed care; 107 = All commercial payers managed care; 110 = Other managed care; 999 = Unknown
Attending physician ID	307-316	10	A/N	L	This field shall contain the National Provider Identifier (NPI) , when assigned, of the physician who has primary responsibility for the patient's medical care and treatment. Prior to NPI assignment, enter the Unique Physician Identification Number (UPIN), or if no UPIN, enter the Missouri license number. All entries must be left-justified.
Principal procedure physician ID	317-326	10	A/N	L	This field shall contain the National Provider Identifier (NPI) , when assigned, of the physician who performed the principal procedure. Prior to NPI assignment, enter the Unique Physician Identification Number (UPIN), or if no UPIN, enter the Missouri license number. All entries must be left-justified.

B-Record
(Continuation Record)

To be used when there are more diagnoses and/or procedures than will fit on the A-Record

Field Name	Relative Position	Field Length	Format	Justify	Description
Record type	1	1	A	L	Constant "B"
Provider identifier	2-11	10	A/N	L	This field shall contain the National Provider Identifier (NPI), when assigned. Prior to NPI assignment, enter the Medicare provider number (or state assigned number).
Unique encounter identifier	12-31	20	A/N	L	Unique identifier within facility (hospital or ASC) for each discharge record or patient encounter.
Other diagnosis codes	32-101	70 (14x5)	A/N	L	ICD-9CM Code
Additional procedures	102-311	210 (14X15)			
Procedure code		(7)	A/N	L	First 7 positions of each 13 position field: The IDC-9CM Code(s) or CPT-4 code(s) for the other procedures
Procedure date		(8)	N	R	Next 6 positions of each 13 position field: MMDDYYYY
Filler	312-326	15			Spaces

C-Record
(Continuation Record)

To be used when census tract information is not available

Field Name	Relative Position	Field Length	Format	Justify	Description
Record type	1	1	A	L	Constant "C"
Provider identifier	2-11	10	A/N	L	This field shall contain the National Provider Identifier (NPI), when assigned. Prior to NPI assignment, enter the Medicare provider number (or state assigned number).
Unique encounter identifier	12-31	20	A/N	L	Unique identifier within facility (hospital or ASC) for each discharge record or patient encounter.
Residence Address Line 1	32-61	30	A/N	L	Free form address line
Residence Address Line 2	62-91	30	A/N	L	Free form address line
City	92-107	16	A/N	L	Name of city or town of residence
Zip code	108-112	5	N	R	First five digits of zip code
Filler	113-326	214			Spaces