PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2515

(Reference to printed bill)

Strike everything after the enacting clause and insert:

"Section 1. Title 36, Arizona Revised Statutes, is amended by adding chapter 38, to read:

CHAPTER 38

CANCER REGISTRY

ARTICLE 1. GENERAL PROVISIONS

36-3801. Definitions

IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "CLINIC" MEANS A FACILITY THAT IS NOT PHYSICALLY CONNECTED TO OR AFFILIATED WITH A HOSPITAL, WHERE A HEALTH PROFESSIONAL PROVIDES CANCER DIAGNOSES OR CANCER TREATMENT, OR BOTH, AND THAT IS ANY OF THE FOLLOWING:

(a) AN OUTPATIENT TREATMENT CENTER AS PRESCRIBED BY THE DEPARTMENT BY RULE.

(b) AN OUTPATIENT SURGICAL CENTER AS PRESCRIBED BY THE DEPARTMENT BY RULE.

(c) AN OUTPATIENT RADIATION TREATMENT CENTER AS PRESCRIBED BY THE DEPARTMENT BY RULE.

2. "DEPARTMENT" MEANS THE DEPARTMENT OF HEALTH SERVICES.

3. "HEALTH PROFESSIONAL" MEANS ANY OF THE FOLLOWING:

(a) A DOCTOR WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 13 OR 17.

(b) A DOCTOR OF NATUROPATHIC MEDICINE WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 14.

(c) A DENTIST WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 11.

(d) A REGISTERED NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15.

36-3802. Cancer reporting requirements; case reports; health professionals; clinics

A. A HEALTH PROFESSIONAL OR A CLINIC MUST PREPARE A CASE REPORT IN A FORMAT PROVIDED BY THE DEPARTMENT THAT INCLUDES THE FOLLOWING INFORMATION:

1. THE NAME, ADDRESS AND TELEPHONE NUMBER OF OR THE IDENTIFICATION NUMBER ASSIGNED BY THE DEPARTMENT TO THE REPORTING FACILITY.

2. THE PATIENT'S NAME, THE PATIENT'S MAIDEN NAME, IF APPLICABLE, AND ANY OTHER NAME BY WHICH THE PATIENT IS KNOWN.

3. THE PATIENT'S ADDRESS AT THE DATE OF LAST CONTACT AND AT THE TIME OF THE DIAGNOSIS OF CANCER.

4. THE PATIENT'S DATE OF BIRTH, SOCIAL SECURITY NUMBER, SEX, RACE AND ETHNICITY.

5. THE DATE OF FIRST CONTACT WITH THE PATIENT FOR THE CANCER BEING REPORTED.

6. THE PATIENT'S USUAL INDUSTRY AND USUAL OCCUPATION, IF THE PATIENT IS AN ADULT.

7. THE PATIENT'S MEDICAL RECORD NUMBER, IF ASSIGNED.

8. THE DATE OF DIAGNOSIS OF THE CANCER BEING REPORTED.

9. IF THE DIAGNOSIS WAS NOT MADE AT THE REPORTING FACILITY, THE NAME AND ADDRESS OF THE FACILITY AT WHICH THE DIAGNOSIS WAS MADE.

10. THE PRIMARY SITE AND SUBSITE OF THE CANCER BEING REPORTED.

11. THE TUMOR SIZE, HISTOLOGY, GRADE AND LATERALITY AT DIAGNOSIS.

12. A CODE THAT DESCRIBES THE PRESENCE OR ABSENCE OF MALIGNANCY IN A TUMOR.

13. WHETHER THE CANCER HAD SPREAD FROM THE PRIMARY SITE AT THE TIME OF DIAGNOSIS, AND IF SO, TO WHERE.

14. THE EXTENT TO WHICH THE CANCER HAS SPREAD FROM THE PRIMARY SITE.

15. A DESCRIPTION OF THE EXTENT TO WHICH THE CANCER HAD SPREAD AT DIAGNOSIS, IF APPLICABLE.

16. WHETHER THE DIAGNOSIS WAS MADE BY HISTOLOGY, CYTOLOGY, CLINICAL EVALUATION, DIAGNOSTIC X-RAY OR ANY OTHER METHOD, OR WHETHER THE METHOD BY WHICH THE DIAGNOSIS WAS MADE IS UNKNOWN.

17. FOR EACH TREATMENT THE PATIENT RECEIVED, THE TYPE OF TREATMENT, DATE OF TREATMENT AND NAME OF THE FACILITY WHERE THE TREATMENT WAS PERFORMED.

18. WHETHER ANY RESIDUAL TUMOR CELLS WERE LEFT AT THE EDGES OF A SURGICAL SITE AFTER SURGERY TO REMOVE A TUMOR AT THE PRIMARY SITE.

19. WHETHER THE PATIENT IS ALIVE OR DECEASED, INCLUDING THE DATE OF LAST CONTACT IF THE PATIENT IS ALIVE, AND THE DATE, PLACE AND CAUSE OF DEATH IF THE PATIENT IS DECEASED.

20. WHETHER OR NOT THE PATIENT HAS EVIDENCE OF A CURRENT CANCER, CARCINOMA IN SITU, OR A BENIGN TUMOR OF THE CENTRAL NERVOUS SYSTEM AS OF THE DATE OF LAST CONTACT OR DEATH, OR WHETHER THIS INFORMATION IS UNKNOWN.

21. THE NAME OF THE HEALTH PROFESSIONAL PROVIDING MEDICAL SERVICES TO THE PATIENT.

22. THE NAME OF THE INDIVIDUAL OR THE CODE THAT IDENTIFIES THE INDIVIDUAL COMPLETING THE CASE REPORT.

23. THE DATE THE CASE REPORT WAS COMPLETED.

24. WHETHER THE PATIENT HAS A HISTORY OF OTHER CANCERS, AND IF SO, IDENTIFICATION OF THE PRIMARY SITE AND THE DATE THE OTHER CANCER WAS DIAGNOSED.

B. THE CANCER REGISTRY OF A HOSPITAL WITH A LICENSED CAPACITY OF FEWER THAN FIFTY INPATIENT BEDS THAT REPORTS AS SPECIFIED PURSUANT TO 36-3803, SUBSECTION A AND THE CANCER REGISTRY OF A HOSPITAL WITH A LICENSED CAPACITY OF FIFTY OR MORE INPATIENT BEDS MUST PREPARE A CASE REPORT IN A FORMAT PRESCRIBED BY THE DEPARTMENT THAT INCLUDES THE INFORMATION SPECIFIED IN SUBSECTION A OF THIS SECTION AND THE FOLLOWING INFORMATION:

1. THE PATIENT'S ACCESSION NUMBER.

2. THE SEQUENCE NUMBER OF THE CANCER BEING REPORTED.

3. THE DATE THE PATIENT WAS ADMITTED TO THE HOSPITAL FOR DIAGNOSTIC EVALUATION, CANCER-DIRECTED TREATMENT, OR EVIDENCE OF CANCER, CARCINOMA IN SITU OR A BENIGN TUMOR OF THE CENTRAL NERVOUS SYSTEM, IF APPLICABLE.

4. THE DATE THE PATIENT WAS DISCHARGED FROM THE HOSPITAL AFTER RECEIVING DIAGNOSTIC EVALUATION OR TREATMENT AT THE HOSPITAL, IF APPLICABLE.

5. THE SOURCE OF PAYMENT FOR THE DIAGNOSIS OR TREATMENT OF CANCER, OR BOTH.

6. THE LEVEL OF THE FACILITY'S INVOLVEMENT IN THE DIAGNOSIS OR TREATMENT, OR BOTH, OF THE PATIENT FOR CANCER.

7. THE YEAR IN WHICH THE HOSPITAL FIRST PROVIDED THE DIAGNOSIS OR TREATMENT TO THE PATIENT FOR THE CANCER BEING REPORTED.

8. THE PATIENT'S COUNTY OF RESIDENCE AT THE TIME OF THE DIAGNOSIS OF CANCER.

9. THE PATIENT'S MARITAL STATUS AND AGE AT THE TIME OF THE DIAGNOSIS OF CANCER, THE PATIENT'S PLACE OF BIRTH AND, IF APPLICABLE, THE NAME OF THE PATIENT'S SPOUSE.

10. IF THE PATIENT IS UNDER EIGHTEEN YEARS OF AGE AND UNMARRIED, THE NAME OF THE PATIENT'S PARENT OR LEGAL GUARDIAN.

11. THE PATIENT'S RELIGIOUS PREFERENCE, IF APPLICABLE.

12. WHETHER THE PATIENT'S LABORATORY RESULTS SHOW THE PRESENCE OF SPECIFIC SUBSTANCES KNOWN AS TUMOR MARKER 1 AND TUMOR MARKER 2, WHICH ARE DERIVED FROM TUMOR TISSUE AND WHOSE DETECTION IN THE BLOOD OF A HUMAN BODY INDICATES THE PRESENCE OF A SPECIFIC TYPE OF TUMOR.

13. A DESCRIPTION OF HOW THE CANCER WAS DIAGNOSED.

14. THE NUMBER OF REGIONAL LYMPH NODES EXAMINED AND THE NUMBER IN WHICH EVIDENCE OF CANCER WAS DETECTED.

15. THE CLINICAL OR PATHOLOGICAL STAGING CLASSIFICATION, BASED ON THE ANALYSIS OF TUMOR, LYMPH NODE AND METASTASIS.

16. THE PATIENT'S CLINICAL OR PATHOLOGICAL STAGE GROUP.

17. THE OCCUPATION OF THE INDIVIDUAL WHO DETERMINED THE CLINICAL OR PATHOLOGICAL STAGE GROUP OF THE PATIENT.

18. A DESCRIPTION OF THE CLINICAL EVALUATION OF X-RAY DIAGNOSTIC FILMS AND SCANS OF THE PATIENT, AND THE DATES OF THE FILMS OR SCANS.

19. A DESCRIPTION OF LABORATORY TESTS PERFORMED FOR THE PATIENT, INCLUDING THE DATE, TYPE AND RESULTS OF ANY TESTS.

1 20. A DESCRIPTION OF THE RESULTS OF THE PATIENT'S CLINICAL EVALUATION.
2 21. THE PROCEDURES USED BY THE REPORTING FACILITY TO OBTAIN A DIAGNOSIS
3 AND STAGING CLASSIFICATION, INCLUDING THE DATES ON WHICH THE PROCEDURES WERE
4 PERFORMED AND THE NAME OF THE FACILITIES WHERE THE PROCEDURES WERE PERFORMED,
5 IF DIFFERENT FROM THE REPORTING FACILITY.
6 22. A DESCRIPTION OF ANY CANCER-RELATED SURGERY ON THE PATIENT,
7 INCLUDING THE DATE AND TYPE OF SURGERY AND THE NAME OF THE FACILITY WHERE THE
8 SURGERY WAS PERFORMED, IF DIFFERENT FROM THE REPORTING FACILITY.
9 23. THE CODE ASSOCIATED WITH THE TYPE OF SURGERY PERFORMED ON THE
10 PATIENT AND THE DATE OF SURGERY.
11 24. THE CODES ASSOCIATED WITH THE:
12 (a) SURGICAL APPROACH.
13 (b) EXTENT OF LYMPH NODE SURGERY.
14 (c) NUMBER OF LYMPH NODES REMOVED.
15 (d) SURGERY OF REGIONAL SITES, DISTANT SITES OR DISTANT LYMPH NODES.
16 (e) REASON FOR NOT PERFORMING SURGERY OR THAT SURGERY WAS PERFORMED.
17 25. WHETHER RECONSTRUCTIVE SURGERY ON THE PATIENT WAS PERFORMED AS A
18 FIRST COURSE OF TREATMENT, WAS DELAYED OR WAS NOT PERFORMED.
19 26. A DESCRIPTION OF CANCER-RELATED RADIATION TREATMENT ADMINISTERED TO
20 THE PATIENT, INCLUDING THE DATE AND TYPE OF RADIATION TREATMENT AND THE NAME
21 OF THE FACILITY WHERE THE RADIATION TREATMENT WAS PERFORMED FROM THE
22 REPORTING FACILITY.
23 27. THE CODE ASSOCIATED WITH THE TYPE OF RADIATION TREATMENT
24 ADMINISTERED TO THE PATIENT AND THE DATE OF RADIATION TREATMENT.
25 28. A DESCRIPTION OF CANCER-RELATED CHEMOTHERAPY ADMINISTERED TO THE
26 PATIENT, INCLUDING THE DATE AND TYPE OF CANCER-RELATED CHEMOTHERAPY AND THE
27 NAME OF THE FACILITY THAT ADMINISTERED THE CHEMOTHERAPY, IF DIFFERENT FROM
28 THE REPORTING FACILITY.
29 29. THE CODE ASSOCIATED WITH THE TYPE OF CHEMOTHERAPY ADMINISTERED TO
30 THE PATIENT AND THE DATE OF CHEMOTHERAPY.
31 30. IF THE PATIENT'S TREATMENT INCLUDED BOTH SURGERY AND RADIATION
32 TREATMENT, THE SEQUENCE OF THE TWO TREATMENTS.

31. IF APPLICABLE, A DESCRIPTION OF ANY OTHER TYPES OF CANCER OR NONCANCER-DIRECTED FIRST COURSE OF TREATMENT THAT ARE NOT OTHERWISE CODED ON THE CASE REPORT FOR THE PATIENT, INCLUDING:

(a) ADDITIONAL SURGERY, CHEMOTHERAPY, RADIATION OR OTHER TREATMENT ADMINISTERED TO THE PATIENT.

(b) THE DATES OF THE TREATMENT.

(c) THE NAMES OF THE FACILITIES WHERE THE TREATMENT WAS PERFORMED, IF DIFFERENT FROM THE REPORTING FACILITY.

(d) THE TYPE OF TREATMENT.

32. IF ADDITIONAL CANCER OF THE TYPE DIAGNOSED AT THE PRIMARY SITE IS FOUND AFTER CANCER-DIRECTED TREATMENT, THE DATE OF DIAGNOSIS AND LOCATION OF THE ADDITIONAL CANCER AND WHETHER THE ADDITIONAL CANCER WAS FOUND AT THE PRIMARY SITE, A REGIONAL SITE OR A DISTANT SITE.

33. IF THE PATIENT HAS DIED, WHETHER AN AUTOPSY WAS PERFORMED.

34. THE TYPE OF RECORDS USED BY THE REPORTING FACILITY TO COMPLETE THE CASE REPORT.

C. THE HEALTH PROFESSIONAL AND CLINIC MUST USE CODES AND A CODING FORMAT SUPPLIED BY THE DEPARTMENT FOR DATA ITEMS SPECIFIED IN SUBSECTIONS A AND B OF THIS SECTION THAT REQUIRE CODES ON THE CASE REPORT.

36-3803. Cancer reporting requirements; case reports; hospitals

A. THE CANCER REGISTRY OF A HOSPITAL WITH A LICENSED CAPACITY OF FIFTY OR MORE INPATIENT BEDS MUST ENSURE THAT THE FOLLOWING ARE SUBMITTED TO THE DEPARTMENT:

1. WITHIN ONE HUNDRED EIGHTY CALENDAR DAYS AFTER THE DATE A PATIENT IS FIRST RELEASED FROM THE HOSPITAL, AN ELECTRONIC CASE REPORT.

2. AN ELECTRONIC FOLLOW-UP REPORT, INCLUDING A CHANGE OF PATIENT ADDRESS, IF APPLICABLE, A SUMMARY OF ADDITIONAL FIRST COURSE OF TREATMENT, IF APPLICABLE, AND THE INFORMATION IN SECTION 36-3802, SUBSECTION A, PARAGRAPHS 17, 18, 19 AND 20 AND SUBSECTION B, PARAGRAPH 33, AT LEAST ANNUALLY FOR ALL LIVING ANALYTIC PATIENTS IN THE HOSPITAL'S CANCER REGISTRY DATABASE AND ALL ANALYTIC PATIENTS IN THE HOSPITAL'S CANCER REGISTRY DATABASE WHO HAVE DIED SINCE THE LAST FOLLOW-UP REPORT.

1 B. THE CANCER REGISTRY OF A HOSPITAL WITH A LICENSED CAPACITY OF FEWER
2 THAN FIFTY INPATIENT BEDS MUST REPORT AS SPECIFIED IN SUBSECTION A OF THIS
3 SECTION OR AT LEAST ONCE EVERY SIX MONTHS OR MUST:
4 1. PREPARE AND SUBMIT A WRITTEN REPORT TO THE DEPARTMENT FOR ALL
5 INDIVIDUALS WHO WERE RELEASED BY THE HOSPITAL SINCE THE LAST REPORT WAS
6 PREPARED AND WHOSE MEDICAL RECORDS INCLUDE ICD-9-CM DIAGNOSIS CODES SPECIFIED
7 IN A LIST PROVIDED TO THE HOSPITAL BY THE DEPARTMENT, CONTAINING ICD-9-CM
8 DIAGNOSIS CODES THAT ARE ARRANGED IN NUMERIC ORDER, AND INCLUDING THE
9 FOLLOWING INFORMATION ASSOCIATED WITH EACH ICD-9-CM DIAGNOSIS CODE:
10 (a) THE INDIVIDUAL'S MEDICAL RECORD NUMBER ASSIGNED BY THE HOSPITAL.
11 (b) THE INDIVIDUAL'S AGE.
12 (c) THE INDIVIDUAL'S ADMISSION AND DISCHARGE DATES.
13 (d) WHETHER THE DIAGNOSIS CODE REFLECTS THE INDIVIDUAL'S PRINCIPAL OR
14 SECONDARY DIAGNOSIS.
15 2. ALLOW THE DEPARTMENT TO REVIEW THE RECORDS LISTED IN 36-3804,
16 SUBSECTION A TO OBTAIN INFORMATION ABOUT A PATIENT AS SPECIFIED IN SECTION
17 36-3802.
18 C. IF A CLINIC SUBMITTED ONE HUNDRED OR MORE CASE REPORTS TO THE
19 DEPARTMENT IN THE PREVIOUS CALENDAR YEAR OR EXPECTS TO SUBMIT ONE HUNDRED OR
20 MORE CASE REPORTS IN THE CURRENT CALENDAR YEAR, THE CLINIC MUST SUBMIT A CASE
21 REPORT TO THE DEPARTMENT FOR EACH PATIENT WHO IS NOT REFERRED BY THE CLINIC
22 TO A HOSPITAL FOR THE FIRST COURSE OF TREATMENT AND ENSURE THAT THE CASE
23 REPORT IS SUBMITTED IN ELECTRONIC FORMAT WITHIN NINETY CALENDAR DAYS AFTER
24 INITIATION OF TREATMENT OF THE PATIENT AT THE CLINIC OR DIAGNOSIS OF CANCER
25 IN THE PATIENT, IF THE CLINIC DID NOT PROVIDE TREATMENT.
26 D. IF A CLINIC SUBMITTED FEWER THAN ONE HUNDRED CASE REPORTS TO THE
27 DEPARTMENT IN THE PREVIOUS CALENDAR YEAR AND EXPECTS TO SUBMIT FEWER THAN ONE
28 HUNDRED CASE REPORTS IN THE CURRENT CALENDAR YEAR, THE CLINIC MUST SUBMIT AN
29 ELECTRONIC OR WRITTEN CASE REPORT TO THE DEPARTMENT FOR EACH PATIENT, WITHIN
30 THIRTY CALENDAR DAYS AFTER THE DATE OF DIAGNOSIS OF CANCER IN THE PATIENT, IF
31 THE CLINIC DIAGNOSES CANCER IN THE PATIENT WITHOUT A PATHOLOGY REPORT FROM A

PATHOLOGY LABORATORY AND DOES NOT REFER THE PATIENT TO A HOSPITAL FOR THE FIRST COURSE OF TREATMENT.

E. A HEALTH PROFESSIONAL MUST SUBMIT AN ELECTRONIC OR WRITTEN CASE REPORT TO THE DEPARTMENT FOR EACH PATIENT WITHIN THIRTY CALENDAR DAYS AFTER THE DATE OF DIAGNOSIS OF CANCER IN THE PATIENT, IF THE HEALTH PROFESSIONAL DIAGNOSES CANCER IN THE PATIENT WITHOUT A PATHOLOGY REPORT FROM A PATHOLOGY LABORATORY AND DOES NOT REFER THE PATIENT TO A HOSPITAL OR CLINIC FOR THE FIRST COURSE OF TREATMENT.

F. A CLINIC OR HEALTH PROFESSIONAL WHO RECEIVES A LETTER FROM THE DEPARTMENT REQUESTING ANY OF THE INFORMATION ABOUT A PATIENT AS SPECIFIED IN SECTION 36-3802 MUST PROVIDE TO THE DEPARTMENT THE REQUESTED INFORMATION ABOUT THE PATIENT WITHIN FIFTY BUSINESS DAYS AFTER THE DATE OF THE REQUEST.

G. A PATHOLOGY LABORATORY MUST ALLOW THE DEPARTMENT TO REVIEW PATHOLOGY REPORTS AT LEAST ONCE EVERY NINETY CALENDAR DAYS TO OBTAIN THE INFORMATION SPECIFIED IN SECTION 36-3802 AND PROVIDE TO THE DEPARTMENT COPIES, IN ELECTRONIC OR WRITTEN FORMAT, OF PATHOLOGY REPORTS OF PATIENTS.

36-3804. Records; review; definition

A. TO ENSURE COMPLETENESS AND ACCURACY OF CANCER REPORTING, ON NOTICE FROM THE DEPARTMENT OF AT LEAST FIVE BUSINESS DAYS, A HOSPITAL, CLINIC OR HEALTH PROFESSIONAL THAT IS REQUIRED TO SUBMIT A REPORT PURSUANT TO SECTION 36-3802 MUST ALLOW THE DEPARTMENT TO REVIEW ANY OF THE FOLLOWING RECORDS, AS ARE APPLICABLE:

1. A REPORT MEETING THE REQUIREMENTS OF SECTION 36-3802, SUBSECTION B, PARAGRAPH 1.

2. PATIENT MEDICAL RECORDS.

3. MEDICAL RECORDS OF INDIVIDUALS NOT DIAGNOSED WITH CANCER.

4. PATHOLOGY REPORTS.

5. CYTOLOGY REPORTS.

6. LOGS CONTAINING INFORMATION ABOUT SURGICAL PROCEDURES, AS PRESCRIBED BY THE DEPARTMENT BY RULE.

7. RECORDS OTHER THAN THOSE SPECIFIED IN THIS SUBSECTION THAT CONTAIN INFORMATION ABOUT DIAGNOSTIC EVALUATION, CANCER-DIRECTED TREATMENT OR OTHER TREATMENT PROVIDED TO AN INDIVIDUAL BY THE HOSPITAL, CLINIC OR HEALTH PROFESSIONAL.

B. THE DEPARTMENT SHALL CONSIDER A HOSPITAL, CLINIC OR HEALTH PROFESSIONAL THAT IS REQUIRED TO REPORT PURSUANT TO SECTION 36-3803 AS MEETING THE REQUIREMENTS OF THAT SECTION IF THE HOSPITAL, CLINIC OR HEALTH PROFESSIONAL SUBMITS A CASE REPORT TO THE DEPARTMENT FOR AT LEAST NINETY-SEVEN PER CENT OF THE PATIENTS FOR WHOM A CASE REPORT IS REQUIRED PURSUANT TO SECTION 36-3803 DURING A CALENDAR YEAR.

C. THE DEPARTMENT SHALL CONSIDER A HOSPITAL THAT IS REQUIRED TO REPORT PURSUANT TO SECTION 36-3803, SUBSECTION A, PARAGRAPH 2 AS MEETING THE REQUIREMENTS OF THAT SECTION IF THE HOSPITAL SUBMITS A FOLLOW-UP REPORT AS PRESCRIBED IN THAT SECTION TO THE DEPARTMENT ONCE EACH CALENDAR YEAR FOR AT LEAST:

1. EIGHTY PERCENT OF ALL ANALYTIC PATIENTS AFTER THE HOSPITAL'S REFERENCE DATE.

2. NINETY PERCENT OF ALL ANALYTIC PATIENTS DIAGNOSED WITHIN THE LAST FIVE YEARS OR AFTER THE HOSPITAL'S REFERENCE DATE, WHICHEVER IS SHORTER.

D. THE DEPARTMENT SHALL RETURN A CASE REPORT THAT IS NOT PREPARED PURSUANT TO SECTION 36-3802 TO THE HOSPITAL, CLINIC OR HEALTH PROFESSIONAL THAT SUBMITTED THE CASE REPORT, IDENTIFYING THE REVISIONS THAT ARE NEEDED IN THE CASE REPORT. THE HOSPITAL, CLINIC OR HEALTH PROFESSIONAL MUST SUBMIT THE REVISED CASE REPORT TO THE DEPARTMENT WITHIN FIFTEEN BUSINESS DAYS AFTER THE DATE THE DEPARTMENT REQUESTS THE REVISION.

E. ON WRITTEN REQUEST BY THE DEPARTMENT, A HOSPITAL MUST PREPARE A CASE REPORT BASED ON A SIMULATED MEDICAL RECORD PROVIDED BY THE DEPARTMENT FOR THE PURPOSE OF DEMONSTRATING THE VARIABILITY WITH WHICH DATA IS REPORTED. THE HOSPITAL MUST RETURN THE CASE REPORT TO THE DEPARTMENT WITHIN FIFTEEN BUSINESS DAYS AFTER THE DATE OF THE REQUEST.

1 36-3805. Noncompliance; disciplinary action; civil penalty
2 A. A HEALTH PROFESSIONAL WHO DOES NOT COMPLY WITH THE REPORTING
3 REQUIREMENTS OF THIS ARTICLE IS SUBJECT TO POSSIBLE DISCIPLINARY ACTION BY
4 THE HEALTH PROFESSIONAL'S BOARD IF THE BOARD DETERMINES THAT THE HEALTH
5 PROFESSIONAL'S NONCOMPLIANCE CONSTITUTES AN ACT OF UNPROFESSIONAL CONDUCT.
6 B. A HOSPITAL OR CLINIC THAT DOES NOT COMPLY WITH THE REPORTING
7 REQUIREMENTS OF THIS ARTICLE MAY BE SUBJECT TO A CIVIL PENALTY AS PRESCRIBED
8 BY THE DEPARTMENT BY RULE."
9 Amend title to conform

MATT HEINZ

2515mh.doc
02/14/2011
12:01 PM
C: jcs