Within the stated calendar quarter, this Title contains all rules made, amended, repealed, renumbered, and recodified; or rules that have expired or were terminated due to an agency being eliminated under sunset law. These rules were either certified by the Governor’s Regulatory Review Council or the Attorney General’s Office; or exempt from the rulemaking process, and filed with the Office of the Secretary of State. Refer to the historical notes for more information. Please note that some rules you are about to remove may still be in effect after the publication date of this Supplement. Therefore, all superseded material should be retained in a separate binder and archived for future reference.

TITLE 09. Health Services

Chapter 04. Department of Health Services - Noncommunicable Diseases

Sections, Parts, Exhibits, Tables or Appendices modified

Article 6. Opioid Poisoning-Related Reporting

R9-6-601 and R9-6-602

☐ REMOVE Supp. 07-2
Pages: 1 - 13

☐ REPLACE with Supp. 17-3
Pages: 1 - 17

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Disclaimer: Please be advised the person listed is the contact of record as submitted in the rulemaking package for this supplement. The contact and other information may change and is provided as a public courtesy.

PUBLISHER

Arizona Department of State
Office of the Secretary of State, Administrative Rules Division
Under Arizona law, the Department of State, Office of the Secretary of State (Office), accepts state agency rule filings and is the publisher of Arizona rules. The Office of the Secretary of State does not interpret or enforce rules in the Administrative Code. Questions about rules should be directed to the state agency responsible for the promulgation of the rule.

Scott Cancelosi, Director
ADMINISTRATIVE RULES DIVISION
September 30, 2017

RULES
A.R.S. § 41-1001(17) states: “‘Rule’ means an agency statement of general applicability that implements, interprets, or prescribes law or policy, or describes the procedures or practice requirements of an agency.”

THE ADMINISTRATIVE CODE
The Arizona Administrative Code is where the official rules of the state of Arizona are published. The Code is the official codification of rules that govern state agencies, boards, and commissions. Virtually everything in your life is affected in some way by rules published in the Arizona Administrative Code, from the quality of air you breathe to the licensing of your dentist. This chapter is one of more than 230 in the Code compiled in 21 Titles.

ADMINISTRATIVE CODE SUPPLEMENTS
Rules filed by an agency to be published in the Administrative Code are updated quarterly. Supplement release dates are printed on the footers of each chapter:

First Quarter: January 1 - March 31
Second Quarter: April 1 - June 30
Third Quarter: July 1 - September 30
Fourth Quarter: October 1 - December 31

For example, the first supplement for the first quarter of 2017 is cited as Supp. 17-1.

HOW TO USE THE CODE
Rules may be in effect before a supplement is released by the Office. Therefore, the user should refer to issues of the Arizona Administrative Register for recent updates to rule Sections.

ARTICLES AND SECTIONS
Rules in chapters are divided into Articles, then Sections. The “R” stands for “rule” with a sequential numbering and lettering system separated into subsections.

HISTORICAL NOTES AND EFFECTIVE DATES
Historical notes inform the user when the last time a Section was updated in the Administrative Code. Be aware, since the Office publishes each quarter by entire chapters, not all Sections are updated by an agency in a supplement release. Many times just one Section or a few Sections may be updated in the entire chapter.

ARIZONA REVISED STATUTE REFERENCES
The Arizona Revised Statutes (A.R.S.) are available online at the Legislature’s website, www.azleg.gov. An agency’s authority note to make rules is often included at the beginning of a chapter. Other Arizona statutes may be referenced in rule under the A.R.S. acronym.

SESSION LAW REFERENCES
Arizona Session Law references in the introduction of a chapter can be found at the Secretary of State’s website, www.azsos.gov/services/legislative-filings.

EXEMPTIONS FROM THE APA
It is not uncommon for an agency to be exempt from the steps outlined in the rulemaking process as specified in the Arizona Administrative Procedures Act, also known as the APA (Arizona Revised Statutes, Title 41, Chapter 6, Articles 1 through 10). Other agencies may be given an exemption to certain provisions of the Act.

An agency’s exemption is written in law by the Arizona State Legislature or under a referendum or initiative passed into law by Arizona voters.

When an agency files an exempt rulemaking package with our Office it specifies the law exemption in what is called the preamble of rulemaking. The preamble is published in the Arizona Administrative Register online at www.azsos.gov/rules, click on the Administrative Register link.

In the Administrative Code the Office includes editor’s notes at the beginning of a chapter indicating that certain rulemaking Sections were made by exempt rulemaking. Exempt rulemaking notes are also included in the historical note at the end of a rulemaking Section.

The Office makes a distinction to certain exemptions because some rules are made without receiving input from stakeholders or the public. Other exemptions may require an agency to propose exempt rules at a public hearing.

EXEMPTIONS AND PAPER COLOR
If you are researching rules and come across rescinded chapters on a different paper color, this is because the agency filed a Notice of Exempt Rulemaking. At one time the office published exempt rules on either blue or green paper. Blue meant the authority of the exemption was given by the Legislature; green meant the authority was determined by a court order. In 2001 the Office discontinued publishing rules using these paper colors.

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Public Services managing rules editor, Rhonda Paschal, assisted with the editing of this chapter.
TITLE 9. HEALTH SERVICES

CHAPTER 4. DEPARTMENT OF HEALTH SERVICES - NONCOMMUNICABLE DISEASES

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ARTICLE 6. OPIOID POISONING-RELATED REPORTING

New Article 6, consisting of Sections R9-4-601 and R9-4-602 made by emergency rulemaking at 23 A.A.R. 2857, effective September 21, 2017, for 180 days (Supp. 17-3).

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ARTICLE 1. DEFINITIONS

R9-4-101. Definitions, General
In this Chapter, unless otherwise specified:
1. “Dentist” means an individual licensed under A.R.S. Title 32, Chapter 11, Article 2.
2. “Department” means the Arizona Department of Health Services.
3. “Diagnosis” means the identification of a disease or injury, by an individual authorized by law to make the identification, that is the cause of an individual’s current medical condition.
4. “Hospital” means the same as in A.A.C. R9-10-201.
6. “Physician” means an individual licensed as a doctor of allopathic medicine under A.R.S. Title 32, Chapter 13, or as a doctor of osteopathic medicine under A.R.S. Title 32, Chapter 17.

Historical Note
Adopted effective September 25, 1991 (Supp. 91-3).
Amended by final rulemaking at 6 A.A.R. 2948, effective July 18, 2000 (Supp. 00-3). Amended by final rulemaking at 12 A.A.R. 179, effective March 11, 2006 (Supp. 06-1).

R9-4-102. Repealed

Historical Note
Adopted effective August 15, 1989 (Supp. 89-3).
Amended effective April 9, 1993 (Supp. 93-2). Section repealed by final rulemaking at 6 A.A.R. 2948, effective July 18, 2000 (Supp. 00-3).

R9-4-103. Repealed

Historical Note
Adopted effective August 15, 1989 (Supp. 89-3).
Amended effective March 4, 1993 (Supp. 93-1). Section repealed by final rulemaking at 7 A.A.R. 55, effective December 12, 2000 (Supp. 00-4).

R9-4-104. Repealed

Historical Note

R9-4-105. Repealed

Historical Note
Adopted effective September 25, 1991 (Supp. 91-3). Section repealed by final rulemaking at 7 A.A.R. 712, effective January 17, 2001 (Supp. 01-1).

ARTICLE 2. PESTICIDE ILLNESS

R9-4-201. Definitions
In this Article, unless otherwise specified:
1. “Cluster illness” means sickness in two or more individuals that is caused by or may be related to one pesticide exposure incident, as determined by the history, signs, or symptoms of the sickness; laboratory findings regarding the individuals; the individuals’ responses to treatment for the sickness; or the geographic proximity of the individuals.
2. “Documented” means evidenced by written information such as pesticide applicator reports, statements of individuals with pesticide illness, or medical records.
3. “Health care professional” means a physician, a registered nurse practitioner, a physician assistant, or any other individual who is authorized by law to diagnose human illness.
4. “Medical director” means the individual designated by a poison control center as responsible for providing medical direction for the poison control center or for approving and coordinating the activities of the individuals who provide medical direction for the poison control center.
5. “Pest” has the same meaning as in A.R.S. Title 3, Chapter 2, Article 5 or as used in A.R.S. Title 3, Chapter 2, Article 6 and A.R.S. Title 32, Chapter 22.
6. “Pesticide” means any substance or mixture of substances, including inert ingredients, intended for preventing, destroying, repelling, or mitigating any pest or intended for use as a plant regulator, defoliant, or desiccant, but does not include an antimicrobial agent, such as a disinfectant, sanitizer, or deodorizer, used for cleaning.
7. “Pesticide illness” means any sickness reasonably believed by a health care professional or medical director to be caused by or related to documented exposure to any pesticide, based upon professional judgment and:
   a. The history, signs, or symptoms of the sickness;
   b. Laboratory findings regarding the individual;
   c. The individual’s response to treatment for the sickness.
8. “Physician assistant” has the same meaning as in A.R.S. § 32-2501.
9. “Poison control center” means an organization that is a member of and may be certified by the American Association of Poison Control Centers.
10. “Registered nurse practitioner” has the same meaning as in A.R.S. § 32-1601.

Historical Note
Adopted effective August 15, 1989 (Supp. 89-3).
Amended effective April 9, 1993 (Supp. 93-2). Former Section R9-4-201 renumbered to R9-4-202; new Section R9-4-201 adopted by final rulemaking at 6 A.A.R. 2948, effective July 18, 2000 (Supp. 00-3).

R9-4-202. Pesticide Illness Reporting Requirements
A health care professional or medical director who participates in the diagnosis of or identifies an individual with pesticide illness shall file a report of pesticide illness with the Department as follows:
1. The health care professional or medical director shall report a pesticide illness within five working days from the date of diagnosis or identification, except:
   a. The health care professional or medical director shall report a pesticide illness where the individual with pesticide illness is hospitalized or dies no later than one working day from the time of hospital admission or death; and
   b. The health care professional or medical director shall report cluster illnesses no later than one working day from the time the second individual with pesticide illness is diagnosed or identified.
2. The health care professional or medical director shall submit the report to the Department by telephone; in person; in a writing sent by fax, delivery service, or mail; or by an electronic reporting system if an electronic reporting system is developed by the Department. The report shall contain the following information:
In this Article, unless otherwise specified:

R9-4-301. Definitions

1. “Adult” means an individual 16 years of age or older.
2. “Child” means an individual younger than 16 years of age.
3. “Clinical laboratory” has the same meaning as in A.R.S. § 36-451.
4. “Patient” means the individual whose blood has been tested for lead content.
5. “Public” means funded by and operated under the direction of the federal or state government or a political subdivision of the state.
6. “Public insurance” means a public program, such as the Arizona Health Care Cost Containment System, KidsCare, Indian Health Services, or TRICARE, that pays for medical services.
7. “Whole blood” means human blood from which plasma, erythrocytes, leukocytes, and thrombocytes have not been separated.

Historical Note
New Section renumbered from R9-4-201 and amended by final rulemaking at 6 A.A.R. 2948, effective July 18, 2000 (Supp. 00-3).

ARTICLE 3. BLOOD LEAD LEVELS

R9-4-302. Reporting Significant Blood Lead Levels

A. A physician who receives a laboratory result showing a level of lead equal to or greater than 10 micrograms of lead per deciliter of whole blood for a child or 25 micrograms of lead per deciliter of whole blood for an adult shall report the blood lead level to the Department as follows:

1. The physician shall report the blood lead level within five working days from the date of receipt of the laboratory result if the blood lead level is less than 10 micrograms of lead per deciliter of whole blood for a child or less than 25 micrograms of lead per deciliter of whole blood for an adult.

2. The physician shall report the blood lead level within one working day from the date of receipt of the laboratory result if the blood lead level is equal to or greater than 10 micrograms of lead per deciliter of whole blood for a child or equal to or greater than 25 micrograms of lead per deciliter of whole blood for an adult.

3. A physician may designate a representative to make the report to the Department on behalf of the physician.

B. A clinical laboratory director shall report to the Department the results of all tests for lead in whole blood as follows:

1. The clinical laboratory director shall report the blood lead test result within five working days from the date of completing the test if the blood lead level is equal to or greater than 10 but less than 45 micrograms of lead per deciliter of whole blood for a child or equal to or greater than 25 but less than 60 micrograms of lead per deciliter of whole blood for an adult.

2. The clinical laboratory director shall report the blood lead test result within one working day from the date of completing the test if the blood lead level is equal to or greater than 45 micrograms of lead per deciliter of whole blood for a child or equal to or greater than 60 micrograms of lead per deciliter of whole blood for an adult.

3. The clinical laboratory director shall report blood test results that are less than 10 micrograms of lead per deciliter of whole blood for a child or less than 25 micrograms of lead per deciliter of whole blood for an adult at least once each month.

4. A clinical laboratory director may designate a representative to make the report to the Department on behalf of the clinical laboratory director.

C. A physician or clinical laboratory director shall submit each report to the Department by telephone; in a writing sent by fax, delivery service, or mail; or by an electronic reporting system authorized by the Department.

D. A report shall include the following information:

1. The patient’s name, address, and telephone number;
2. The patient’s date of birth;
3. The patient’s gender;
4. If the patient is an adult, the patient’s occupation and the name, address, and telephone number of the patient’s employer;
5. An indication of the patient’s funding source and the specific health plan name, if applicable:
   a. Public insurance;
   b. Private insurance;
   c. Self-pay;
   d. Workplace monitoring program;
   e. Other, or
   f. Unknown;
6. The type of blood draw used (venous or capillary);
7. The date the blood was drawn;
8. The blood lead level;
9. The date the blood lead level was received by the physician or determined by the laboratory;
10. The name, address, and telephone number of the laboratory that tested the blood; and
11. The name, practice name, address, and telephone number of the physician who ordered the test.

Historical Note
New Section renumbered from R9-4-301 and amended by final rulemaking at 7 A.A.R. 55, effective December 12, 2000 (Supp. 00-4).
**ARTICLE 4. CANCER REGISTRY**

**R9-4-401. Definitions**

In this Article, unless otherwise specified:

1. “Accession number” means a unique number, separate from a medical record number, assigned by a hospital’s cancer registry to a patient for identification purposes.
2. “Admitted” means the same as in A.A.C. R9-10-201.
3. “Analytic patient” means a patient, who is:
   a. Diagnosed at a facility, or
   b. Administered any part of a first course of treatment at the facility.
4. “Basal cell” means a cell of the inner-most layer of the skin.
6. “Business day” means any day of the week other than a Saturday, a Sunday, a legal holiday, or a day on which the Department is authorized or obligated by law or executive order to close.
7. “Calendar day” means any day of the week, including a Saturday or a Sunday.
8. “Calendar year” means January 1 through December 31.
9. “Cancer” means a group of diseases characterized by uncontrolled cell growth and the spread of abnormal cells.
10. “Cancer registry” means a unit within a hospital or clinic that collects, stores, summarizes, distributes, and maintains information specified in R9-4-403 about patients who:
   a. Are admitted to the hospital;
   b. Receive diagnostic evaluation at, or cancer-directed treatment from, the hospital or clinic; or
   c. Show evidence of cancer, carcinoma in situ, or a benign tumor of the central nervous system while receiving treatment from the hospital or clinic.
11. “Carcinoma” means a type of cancer that is characterized as a malignant tumor derived from epithelial tissue.
12. “Carcinoma in situ” means a cancer that is confined to epithelial tissue within the site of origin.
13. “Case report” means an electronic or paper document that includes the information in R9-4-403 for a patient.
14. “Chemotherapy” means the treatment of cancer using specific chemical agents or drugs that are selectively destructive to malignant cells and tissues.
15. “Clinic” means a facility that is not physically connected to or affiliated with a hospital, where a physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner provides cancer diagnosis, cancer treatment, or both, and that is:
   a. An outpatient treatment center, as defined in A.A.C. R9-10-101,
   b. An outpatient surgical center, as defined in A.A.C. R9-10-101, or
   c. An outpatient radiation treatment center.
16. “Clinical evaluation” means an examination of the body of an individual for the presence of disease or injury to the body, and review of any laboratory test results for the individual by a physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner.
17. “Clinical or pathological” means an analysis of evidence either acquired solely before a first course of treatment was initiated, or acquired both before a first course of treatment, and supplemented or modified by evidence acquired during and subsequent to surgery.
18. “Code” means a single number or letter, a set of numbers or letters, or a set of both numbers and letters, that represents specific information.
19. “Cytology” means the microscopic examination of cells.
20. “Date of first contact” means the day, month, and year a reporting facility first began to provide cancer-related medical services, nursing services, or health-related services, as defined in A.R.S. § 36-401, to a patient.
21. “Date of last contact” means the day, month, and year that a reporting facility last knew a patient to be alive.
22. “Designee” means a person assigned by the governing authority of a hospital or clinic or by an individual acting on behalf of the governing authority to gather information for or report to the Department, as specified in R9-4-403 or R9-4-404.
23. “Discharge” means the same as in A.A.C. R9-10-201.
24. “Discharge date” means the month, day, and year when a patient is discharged from a hospital.
25. “Disease progression” means the process of a disease becoming more severe or spreading from one area of a human body to another area of the human body.
26. “Distant lymph node” means a lymph node that is not in the same general area of a human body as the primary site of a tumor.
27. “Distant site” means an area of a human body that is not adjacent to or in the same general area of the human body as the primary site of a tumor.
29. “Electronic” means the same as in A.R.S. § 44-7002.
30. “First course of treatment” means the initial set of cancer or non-cancer-directed treatment that is planned when a cancer is diagnosed and administered to the patient before disease progression or recurrence.
31. “Follow-up report” means an electronic document that includes the information stated in R9-4-404(A)(2) for a patient.
32. “Governing authority” means the same as in A.R.S. § 36-401.
33. “Grade” means the degree of resemblance of a tumor to normal tissue, and gives an indication of the severity of the cancer.
34. “Health care institution” means the same as in A.A.C. R9-10-101.
35. “Histology” means the microscopic structure of cells, tissues, and organs in relation to their function.
36. “Inpatient beds” means the same as in A.R.S. § 36-401.
37. “Laterality” means the side of a paired organ or the side of the body in which the primary site of a tumor is located.
38. “Licensed capacity” means the same as in A.R.S. § 36-401.
39. “Lymph” means the clear, watery, sometimes faintly yellowish fluid that circulates throughout the lymphatic system.
40. “Lymph node” means any of the small bodies located along lymphatic vessels, particularly at the neck, armpit, and groin, that filter bacteria and foreign particles from lymph.
41. “Lymphatic system” means the organ system that consists of lymph, lymph nodes, and vessels or channels that contain and convey lymph throughout a human body.
42. “Malignant” means an inherent tendency of a tumor to sequentially spread to areas of a human body beyond the site of origin.
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43. “Medical record number” means a unique number assigned by a hospital, clinic, physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner to an individual for identification purposes.

44. “Melanocyte” means a skin cell that makes melanin, which is a dark pigment.

45. “Melanoma” means a dark-pigmented, malignant tumor arising from a melanocyte and occurring most commonly in the skin.

46. “Metastasis” means the spread of a cancer from a primary site into a regional site or a distant site.

47. “Narrative description” means a written text describing an act, occurrence, or course of events.

48. “Organ” means a somewhat independent part of a human body, such as a heart or a kidney, that performs a specific function.

49. “Organ system” means one or more organs and associated tissues that perform a specific function, such as the circulatory system.

50. “Outpatient radiation treatment center” means a facility in which a person, licensed as specified in 12 A.A.C. 1, Article 7, provides radiation treatment.

51. “Papillary tumor” means a benign tumor of the skin producing finger-like projections from the skin surface.

52. “Pathology laboratory” means a facility in which human cells or tissues are examined for the purpose of diagnosing cancer and that is licensed under 9 A.A.C. 10, Article 1.

53. “Patient” means an individual who has been diagnosed with a cancer, carcinoma in situ, or benign tumor of the central nervous system, including melanoma, but excluding skin cancer that is:
   a. Confined to the primary site; or
   b. Present at regional sites or distant sites, but was diagnosed on or after January 1, 2003.

54. “Primary site” means a specific organ or organ system within a human body where the first cancer tumor originated.

55. “Principal diagnosis” means the primary condition for which an individual is admitted to a hospital or treated by the hospital.

56. “Radiation treatment” means the exposure of a human body to a stream of particles or electromagnetic waves for the purpose of selectively destroying certain cells or tissues.

57. “Reconstructive surgery” means a medical procedure that involves cutting into a body tissue or organ with instruments to repair damage or restore function to, or improve the shape and appearance of a body structure that is missing, defective, damaged, or misshapen by cancer or cancer-directed therapies.

58. “Recurrence” means the reappearance of a tumor after previous removal or treatment of the tumor, after a period in which the patient was believed to be free of cancer.

59. “Reference date” means the date on which the hospital’s cancer registry began reporting patient information to the Department.

60. “Regional lymph node” means a lymph node that is in the same general area of a human body as the primary site of a tumor.

61. “Regional site” means an area of a human body that is adjacent to or in the same general area of the human body as the primary site of a tumor.

62. “Registered nurse practitioner” means an individual who meets the definition of registered nurse practitioner in A.R.S. § 32-1601, and is licensed under A.R.S. Title 32, Chapter 15.

63. “Rehabilitation services” means the same as in A.A.C. R9-10-201.

64. “Release” means to transfer care of a patient from a hospital to a physician, a doctor of naturopathic medicine, a registered nurse practitioner, an outpatient treatment center, another hospital, the patient, the patient’s parent if the patient is under 18 years of age and unmarried, or the patient’s legal guardian.

65. “Reporting facility” means a hospital, clinic, physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner that submits a case report to the Department.

66. “Secondary diagnosis” means all other diagnoses of an individual made after the principal diagnosis.

67. “Sequence number” means a unique number assigned by a cancer registry to a specific cancer within the body of a patient.

68. “Skin cancer” means cancer of any of the following types:
   a. Papillary tumor;
   b. Squamous cell;
   c. Basal cell; or
   d. Other carcinoma of the skin, where a specific diagnosis has not been determined.

69. “Special hospital” means the same as in A.A.C. R9-10-201.

70. “Squamous cell” means a flat, scale-like skin cell.

71. “Stage group” means a scheme for categorizing a patient, based on the staging classification of the patient’s cancer, to enable a physician, doctor of naturopathic medicine, or registered nurse practitioner to provide better treatment and outcome information to the patient.

72. “Staging classification” means the categorizing of a cancer according to the size and spread of a tumor from its primary site, based on an analysis of three basic components:
   a. The tumor at the primary site,
   b. Regional lymph nodes, and
   c. Metastasis.

73. “Subsite” means a specific area within a primary site where a cancer tumor originated.

74. “Substantiate stage” means a narrative describing the stage group of a cancer at the time of diagnosis.

75. “Treatment” means the administration to a patient of medical services, nursing services, or health-related services, as defined in A.R.S. § 36-401, that are intended to relieve illness or injury.

76. “Tumor” means an abnormal growth of tissue resulting from uncontrolled multiplication of cells and serving no physiological function.

77. “Usual industry” means the primary type of activity carried out by the business where a patient was employed for the most number of years of the patient’s working life before the diagnosis of cancer.

78. “Usual occupation” means the kind of work performed during the most number of years of a patient’s working life before the diagnosis of cancer.

79. “Working life” means that portion of a patient’s life during which the patient was employed for a salary or wages.

Historical Note
Adopted effective January 1, 1992, filed September 25, 1991 (Supp. 91-3). Section repealed; new Section made by final rulemaking at 12 A.A.R. 179, effective March...
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11, 2006 (Supp. 06-1). Amended by final rulemaking at 3708, effective November 11, 2006 (Supp. 06-3).

R9-4-401. Repealed

Historical Note
New Section made by final rulemaking at 9 A.A.R. 1859, effective June 3, 2003 (Supp. 03-2). Section repealed by final rulemaking at 12 A.A.R. 179, effective March 11, 2006 (Supp. 06-1).

R9-4-402. Exceptions
This Article does not apply to a hospital that is:
1. Licensed as a special hospital and a behavioral health service agency; or
2. A special hospital that limits admission to individuals requiring rehabilitation services.

Historical Note
Adopted effective January 1, 1992, filed September 25, 1991 (Supp. 91-3). Section repealed; new Section made by final rulemaking at 12 A.A.R. 179, effective March 11, 2006 (Supp. 06-1).

R9-4-403. Case Reports
A. A physician, doctor of naturopathic medicine, dentist, registered nurse practitioner, or the designee of a clinic shall:
1. Prepare a case report in a format provided by the Department;
2. Include the following information in the case report:
   a. The name, address, and telephone number, or the identification number assigned by the Department to the reporting facility;
   b. The patient’s name, and if applicable, the patient’s maiden name and any other name by which the patient is known;
   c. The patient’s address at the date of last contact, and address at diagnosis of cancer;
   d. The patient’s date of birth, Social Security number, sex, race, and ethnicity;
   e. The date of first contact with the patient for the cancer being reported;
   f. The patient’s usual industry and usual occupation, if the patient is an adult;
   g. The patient’s medical record number, if assigned;
   h. The date of diagnosis of the cancer being reported;
   i. If the diagnosis was not made at the reporting facility, the name and address of the facility at which the diagnosis was made;
   j. The primary site and subsite of the cancer being reported;
   k. The tumor size, histology, grade, and laterality at diagnosis;
   l. A code that describes the presence or absence of malignancy in a tumor;
   m. Whether the cancer had spread from the primary site at the time of diagnosis and if so, to where;
   n. The extent to which the cancer has spread from the primary site;
   o. A narrative description of the extent to which the cancer had spread at diagnosis;
   p. 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;
   q. For each treatment the patient received, the type of treatment, date of treatment, and the name of the facility where the treatment was performed;
   r. Whether any residual tumor cells were left at the edges of a surgical site, after surgery to remove a tumor at the primary site;
   s. Whether the patient is alive or dead, including the date of last contact if the patient is alive, and the date, place, and cause of death if the patient is dead;
   t. Whether or not the patient has evidence of a current cancer, carcinoma in situ, or benign tumor of the central nervous system as of the date of last contact or death, or whether this information is unknown;
   u. The name of the physician, nurse practitioner, or doctor of naturopathic medicine providing medical services, as defined in A.R.S. § 36-401, to the patient;
   v. The name of the individual or the code that identifies the individual completing the case report;
   w. The date the case report was completed; and
   x. 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; and
3. Use codes and a coding format supplied by the Department for data items specified in subsection (A)(2) that require codes on the case report.

B. The cancer registry of a hospital with a licensed capacity of fewer than 50 inpatient beds that reports as specified in R9-4-404(A) and the cancer registry of a hospital with a licensed capacity of 50 or more inpatient beds shall:
1. Prepare a case report in a format provided by the Department;
2. Include the information specified in subsection (A) and the following information on the case report:
   a. The patient’s accession number;
   b. The sequence number of the cancer being reported;
   c. 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;
   d. The date the patient was discharged from the hospital after the patient received diagnostic evaluation or treatment at the hospital, if applicable;
   e. The source of payment for diagnosis or treatment of cancer, or both;
   f. The level of the facility’s involvement in the diagnosis or treatment, or both, of the patient for cancer;
   g. The year in which the hospital first provided diagnosis or treatment to the patient for the cancer being reported;
   h. The patient’s county of residence at diagnosis of cancer;
   i. The patient’s marital status and age at diagnosis of cancer, place of birth, and, if applicable, name of the patient’s spouse;
   j. If the patient is under 18 years of age and unmarried, the name of the patient’s parent or legal guardian;
   k. The patient’s religious preference, if applicable;
   l. 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;
   m. A narrative description of how the cancer was diagnosed;
   n. The number of regional lymph nodes examined and the number in which evidence of cancer was detected;
o. The clinical or pathological staging classification, based on the analysis of tumor, lymph node, and metastasis;
p. The patient’s clinical or pathological stage group;
q. The occupation of the individual who determined the clinical or pathological stage group of the patient;
r. A narrative description of the clinical evaluation of x-ray diagnostic films and scans of the patient, and the dates of the films or scans;
s. A narrative description of laboratory tests performed for the patient, including the date, type, and results of any of the patient’s laboratory tests;
t. A narrative description of the results of the patient’s clinical evaluation;
u. The procedures used by the reporting facility to obtain a diagnosis and staging classification, including the dates on which the procedures were performed, and the name of the facilities where the procedures were performed, if different from the reporting facility;
v. A narrative description of any cancer-related surgery on the patient, including the date of surgery, name of the facility where the surgery was performed, if different from the reporting facility, and type of surgery;
w. The code associated with the type of surgery performed on the patient and the date of surgery;
x. The codes associated with the:
i. Surgical approach;
ii. Extent of lymph node surgery;
iii. Number of lymph nodes removed;
iv. Surgery of regional sites, distant sites, or distant lymph nodes; and
v. Reason for no surgery or that surgery was performed;
y. Whether reconstructive surgery on the patient was performed as a first course of treatment, delayed, or not performed;
z. A narrative description of cancer-related radiation treatment administered to the patient, including the date of radiation treatment, name of the facility where the radiation treatment was performed, if different from the reporting facility, and type of radiation treatment;
za. The code associated with the type of radiation treatment administered to the patient and the date of radiation treatment;
zb. A narrative description of cancer-related chemotherapy administered to the patient, including the date of cancer-related chemotherapy, name of the facility that administered the chemotherapy, if different from the reporting facility, and type of chemotherapy;
cc. The code associated with the type of chemotherapy administered to the patient and the date of chemotherapy;
zd. If the patient’s treatment included both surgery and radiation treatment, the sequence of the two treatments;
ze. If applicable, a narrative description of any other types of cancer or non-cancer-directed first course of treatment, not otherwise coded on the case report for the patient, including:
i. Additional surgery, chemotherapy, radiation, or other treatment, administered to the patient;
ii. The dates of the treatment;
iii. The names of the facilities where the treatment was performed, if different from the reporting facility; and
iv. The type of treatment;
ff. If additional cancer of the type diagnosed at the primary site is found after cancer-directed treatment, the date and location of the additional cancer, and whether the additional cancer was found at the primary site, a regional site, or a distant site;
gg. If the patient has died, whether an autopsy was performed; and
hh. The type of records used by the reporting facility to complete the case report; and
3. Use codes and coding format supplied by the Department for data items specified in subsection (B)(2) that require codes in the case report.

R9-4-404. Requirements for Submitting Case Reports and Allowing Review of Hospital Records
A. The cancer registry of a hospital with a licensed capacity of 50 or more inpatient beds shall ensure that:
1. An electronic case report is submitted to the Department within 180 calendar days from the date a patient is first released from the hospital; and
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 R9-4-403(A)(2)(q), (s), (t), and (u) and R9-4-403(B)(2)(gg), is submitted to the Department at least annually for:
   a. All living analytic patients in the hospital’s cancer registry database, and
   b. All analytic patients in the hospital’s cancer registry database who have died since the last follow-up report.
B. The cancer registry or other designee of a hospital with a licensed capacity of fewer than 50 inpatient beds shall either report as specified in subsection (A), or shall at least once every six months:
1. Prepare and submit a written report to the Department:
   a. For all individuals:
      i. Released by the hospital since the last report was prepared, and
      ii. Whose medical records include ICD-9-CM diagnosis codes specified in a list provided to the hospital by the Department,
   b. Containing ICD-9-CM diagnosis codes that are arranged in numeric order, and
   c. Including the following information associated with each ICD-9-CM diagnosis code:
      i. The individual’s medical record number assigned by the hospital,
      ii. The individual’s age,
      iii. The individual’s admission and discharge dates, and
      iv. Whether the diagnosis code reflects the individual’s principal or secondary diagnosis, and
2. Allow the Department to review the records listed in R9-4-405(A) to obtain the information specified in R9-4-403 about a patient.

C. If the designee of a clinic submitted fewer than 100 case reports to the Department in the previous calendar year or expects to submit 100 or more case reports in the current calendar year, the designee of the clinic shall:
   1. Submit a case report to the Department for each patient who is not referred by the clinic to a hospital for the first course of treatment; and
   2. Ensure that the case report in subsection (C)(1) is submitted in electronic format within 90 calendar days of:
      a. Initiation of treatment of the patient at the clinic; or
      b. Diagnosis of cancer in the patient, if the clinic did not provide treatment.

D. If the designee of a clinic submitted fewer than 100 case reports to the Department in the previous calendar year and expects to submit fewer than 100 case reports in the current calendar year, the designee of the clinic shall submit an electronic or paper case report to the Department for each patient, within 30 calendar days from the date of diagnosis of cancer in the patient, if the clinic:
   1. Diagnoses cancer in the patient without a pathology report from a pathology laboratory, and
   2. Does not refer the patient to a hospital for the first course of treatment.

E. A physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner shall submit an electronic or paper case report to the Department for each patient, within 30 calendar days from the date of diagnosis of cancer in the patient, if the physician, doctor of naturopathic medicine, dentist, or registered nurse practitioner:
   1. Diagnoses cancer in the patient without a pathology report from a pathology laboratory, and
   2. Does not refer the patient to a hospital or clinic for the first course of treatment.

F. A clinic, physician, dentist, registered nurse practitioner, or doctor of naturopathic medicine that receives a letter from a pathology laboratory, and
   1. Diagnoses cancer in the patient without a pathology report from a pathology laboratory, and
   2. Does not refer the patient to a hospital or clinic for the first course of treatment.

G. A clinic, physician, dentist, registered nurse practitioner, or doctor of naturopathic medicine that receives a letter from a pathology laboratory:
   1. Diagnoses cancer in the patient without a pathology report from a pathology laboratory, and
   2. Provides to the Department copies, in electronic or written format, of pathology reports of patients.

Historical Note

ARTICLE 5. BIRTH DEFECTS MONITORING PROGRAM

R9-4-501. Definitions
In this Article, unless otherwise specified:
1. “Admitted” means the same as in A.A.C. R9-10-201.
2. “Birth defect” means an abnormality:
   a. Of body structure, function, or chemistry, or of chromosomal structure or composition;
   b. That is present at or before birth; and
20. “Estimated gestational age” means an approximation of the duration of a pregnancy, based on the date of the last menstrual period of the pregnant woman.

21. “Facility” means a building and associated personnel and equipment that perform or are used in connection with performing a particular service or activity.

22. “Family medical history” means an account of past and present illnesses or diseases experienced by individuals who are biologically related to a patient.

23. “Follow-up services” means activities intended to assist the parent or guardian of a patient who has a birth defect to:
   a. Learn about the birth defect and, if applicable, how the birth defect may be prevented; or
   b. Obtain applicable medical services, nursing services, health-related services, or support services.

24. “Genetic condition” means a disease or other abnormal state present at birth or before birth, as a result of an alteration in DNA, that impairs normal physiological functioning of a human body.

25. “Genetic testing facility” means an organization, institution, corporation, partnership, business, or entity that conducts tests to detect, analyze, or diagnose a genetic condition in an individual, including an evaluation to determine the structure of an individual’s chromosomes.

26. “Governing power” means the individual, agency, group, or corporation appointed, elected, or otherwise designated, in which the ultimate responsibility and authority for the conduct of a hospital, high-risk perinatal practice, genetic testing facility, or prenatal diagnostic facility are vested.

27. “Guardian” means an individual appointed as a legal guardian by a court of competent jurisdiction.

28. “Health-related services” means the same as in A.R.S. § 36-401.

29. “High-risk perinatal practice” means a clinic or physician that routinely provides medical services perinatally to a patient or a patient’s mother with perinatal risk factors to prevent, clinically evaluate, diagnose, or treat the patient for a possible birth defect.

30. “Log” means a chronological list of individuals for or on whom medical services, nursing services, or health-related services were provided by a designated unit of a hospital or by another person specified in R9-4-503(A).

31. “Medical condition” means a disease, injury, other abnormal physiological state, or pregnancy.

32. “Medical records” means the same as in A.R.S. § 12-2291.

33. “Medical record number” means a unique number assigned by a hospital, clinic, physician, or registered nurse practitioner to an individual for identification purposes.

34. “Medical services” means the same as in A.R.S. § 36-401.

35. “Midwife” means an individual licensed under A.R.S. Title 36, Chapter 6, Article 7, or certified under A.R.S. Title 36, Chapter 2, Article 3.

36. “Mother” means the woman:
   a. Who is pregnant with or gives birth to a patient, or
   b. From whose fertilized egg a patient develops.

37. “Multiple gestation” means a pregnancy in which a patient is not the only fetus carried in a mother’s womb.

38. “Nursing services” means the same as in A.R.S. § 36-401.

39. “Ordered” means instructed by a physician, registered nurse practitioner, or physician assistant to perform a test on an individual.

40. “Parent” means the:
   a. Biological or adoptive father of an individual; or
b. Woman who:
   i. Is the mother of an individual; or
   ii. Adopts an individual.
41. “Pathology laboratory” means a facility in which human cells, body fluids, or tissues are examined for the purpose of diagnosing diseases and that is licensed under 9 A.A.C. 10, Article 1.
42. “Patient” means an individual, regardless of current age:
   a. Who, from conception to one year of age, was clinically evaluated for a possible birth defect or a medical condition that may be related to a birth defect:
      i. By:
         (1) A physician,
         (2) A midwife,
         (3) A registered nurse practitioner, or
         (4) A physician assistant; or
      ii. At a hospital or clinic;
   b. Whose mother was clinically evaluated during her pregnancy with the individual:
      i. For a medical condition that may be related to a possible birth defect, and
      ii. By an individual or facility specified in subsection (42)(a);
   c. Who, from conception to one year of age, was tested by a genetic testing facility or other clinical laboratory;
   d. Whose mother was tested during her pregnancy with the individual by:
      i. Genetic testing facility or other clinical laboratory, or
      ii. Prenatal diagnostic facility; or
   e. Who, from conception to one year of age, was provided treatment or whose mother during her pregnancy with the individual was provided treatment by a hospital, clinic, physician, registered nurse practitioner, or other person specified in R9-4-503(A) for a medical condition that may be related to a possible birth defect.
43. “Perinatal risk factor” means a situation or circumstance that may increase the chance of an individual being born with a birth defect, such as:
   a. A family medical history of birth defects or other medical conditions;
   b. The exposure of the individual or the individual’s mother or biological father to radiation, medicines, chemicals, or diseases before the individual’s birth; or
   c. An abnormal result of a test performed for the individual or the individual’s mother by a prenatal diagnostic facility or clinical laboratory, including a genetic testing facility.
44. “Physician assistant” means an individual licensed under A.R.S. Title 32, Chapter 25.
45. “Prenatal diagnostic facility” means an organization, institution, corporation, partnership, business, or entity that conducts diagnostic ultrasound or other medical procedures that may diagnose a birth defect in a human being.
46. “Principal diagnosis” means the primary reason for which an individual is:
   a. Admitted to a hospital;
   b. Treated by a hospital, clinic, physician, registered nurse practitioner, or physician assistant; or
   c. Tested by a genetic testing facility or prenatal diagnostic facility.
47. “Procedure” means a set of activities performed on a patient or the mother of a patient that:
   a. Are invasive;
   b. Are intended to diagnose or treat a disease, illness, or injury;
   c. Involve a risk to the patient or patient’s mother from the activities themselves or from anesthesia; and
   d. Require the individual performing the set of activities to be trained in the set of activities.
48. “Refer” means to provide direction to an individual or the individual’s parent or guardian to obtain medical services or a test for assessment, diagnosis, or treatment of a birth defect or other medical condition.
49. “Registered nurse practitioner” means an individual who meets the definition of registered nurse practitioner in A.R.S. § 32-1601, and is licensed under A.R.S. Title 32, Chapter 15.
50. “Routinely” means occurring in the regular or customary course of business.
51. “Secondary diagnosis” means all other diagnoses for an individual besides the principal diagnosis.
52. “Singleton gestation” means a pregnancy in which a patient is the only fetus carried in a mother’s womb.
53. “Support services” means activities, not related to the diagnosis or treatment of a birth defect, intended to maintain or improve the physical, mental, or psychosocial capabilities of a patient or those individuals biologically or legally related to the patient.
54. “Surgical procedure” means making an incision into an individual’s body for the:
   a. Correction of a deformity or defect,
   b. Repair of an injury,
   c. Excision of a part of the individual’s body, or
   d. Diagnosis, amelioration, or cure of a disease.
55. “Test” means:
   a. An analysis performed on body fluid, tissue, or excretion by a genetic testing facility or other clinical laboratory to evaluate for the presence or absence of a disease; or
   b. A procedure performed on the body of a patient or the patient’s mother that may be used to evaluate for the presence or absence of a birth defect.
56. “Transfer” means for a hospital to discharge a patient or the patient’s mother and send the patient or the patient’s mother to another hospital for inpatient medical services without the intent that the patient or the patient’s mother will return to the sending hospital.
58. “Unit” means an area of a hospital designated to provide an organized service, as defined in A.A.C. R9-10-201.

Historical Note
Adopted effective September 25, 1991 (Supp. 91-3).
Former Section R9-4-501 renumbered to R9-4-502; new Section R9-4-501 adopted by final rulemaking at 7 A.A.R. 712, effective January 17, 2001 (Supp. 01-1).
Amended by final rulemaking at 13 A.A.R. 1702, effective June 30, 2007 (Supp. 07-2).

R9-4-502. Reporting Sources; Information Submitted to the Department
A. The designee of a hospital shall:
1. Prepare a written report each month in a format specified by the Department identifying all individuals:
   a. Who are patients or the mothers of patients; and
   b. Whose:
2. Include the following information in the report specified in subsection (A)(1):
   a. The name, address, and telephone number of the hospital, or the identification number assigned by the Department to the hospital;
   b. The name and telephone number of the designee of the hospital;
   c. The date the report was completed;
   d. The month for which the report is being prepared;
   e. For each patient or the mother of the patient:
      i. The name of the patient or patient’s mother;
      ii. The race and ethnicity of the patient or patient’s mother;
      iii. The mother’s date of birth;
      iv. The patient’s gender, if known;
      v. The patient’s gender and date of birth, if applicable;
      vi. The admission and discharge dates;
      vii. The principal and secondary diagnoses or the ICD-9-CM diagnosis codes for the principal and secondary diagnoses for the patient or patient’s mother; and

3. Submit the report specified in subsection (A)(1) to the Department, in a format specified by the Department, within 30 calendar days after the end of the month for which the report is being prepared.

The designee of a high-risk perinatal practice shall:
1. Prepare a written report each month in a format specified by the Department, for all individuals:
   a. Who are patients or the mothers of patients, and
   b. For whom the genetic testing facility performed a test:
      i. Completed within the month for which the report is being prepared, as specified in subsection (C)(2)(d); and
      ii. Specified in a list provided by the Department to the genetic testing facility;

2. Include the following information in the report specified in subsection (C)(1):
   a. The name, address, and telephone number of the genetic testing facility, or the identification number assigned by the Department to the genetic testing facility;
   b. The name and telephone number of the designee of the genetic testing facility;
   c. The date the report was completed;
   d. The month for which the report is being prepared; and
   e. For each patient or mother of a patient:
      i. If the test was performed on the patient:
         (1) The patient’s name, date of birth, and gender; and
         (2) The name of the patient’s parent or guardian;
      ii. If the test was performed on the mother of the patient:
         (1) The mother’s name and date of birth;
         (2) The estimated gestational age of the patient when the test was performed, if available; and
         (3) The mother’s estimated date of confinement when the test was performed, if available;
      iii. The name of the physician, registered nurse practitioner, or physician assistant who ordered the test for the patient or the patient’s mother; and
      iv. Information about the test, including:
         (1) The type of test performed on the patient or the patient’s mother,
         (2) The date the test was completed, and
         (3) The results of the test; and
3. Submit the report specified in subsection (C)(1) to the Department, in a format specified by the Department, within 30 calendar days after the end of the month for which the report is being prepared.

D. The designee of a prenatal diagnostic facility shall:
   1. Submit an electronic or paper report to the Department:
      a. For each mother:
         i. On whom the prenatal diagnostic facility conducts a test specified in a list provided by the Department to the prenatal diagnostic facility, and
         ii. Whose test result indicates a diagnosis specified in a list provided by the Department to the prenatal diagnostic facility; and
      b. Within 30 calendar days from the date of the test;
   2. Include the following information in the report specified in subsection (D)(1):
      a. The name, address, and telephone number of the prenatal diagnostic facility, or the identification number assigned by the Department to the prenatal diagnostic facility;
      b. The name and telephone number of the designee of the prenatal diagnostic facility;
      c. The date the report was completed;
      d. The mother’s name and date of birth;
      e. The estimated gestational age of the patient at the time of the test;
      f. The mother’s estimated date of confinement;
      g. The outcome of the pregnancy, if known;
      h. The name of the physician, registered nurse practitioner, or physician assistant who ordered the test for the mother; and
      i. Information about the test, including:
         i. The type of test performed on the mother, ii. The date the test was completed, and
         iii. The results of the test.

   Historical Note
   Adopted effective September 25, 1991 (Supp. 91-3). New Section R9-4-502 renumbered from R9-4-501 and amended by final rulemaking at 7 A.A.R. 712, effective January 17, 2001 (Supp. 01-1). Section repealed; new Section made by final rulemaking at 13 A.A.R. 1702, effective June 30, 2007 (Supp. 07-2).

R9-4-503. Review of Records; Information Collected
A. Upon notice from the Department of at least five business days, the following persons or facilities shall allow the Department access to the facility and the electronic or written records specified in subsection (B)(1) to collect the information specified in subsection (B)(2):
   1. A hospital,
   2. A clinic,
   3. A physician,
   4. A midwife,
   5. A registered nurse practitioner,
   6. A genetic testing facility,
   7. A prenatal diagnostic facility,
   8. A physician assistant,
   9. A clinical laboratory, or
   10. A medical examiner.
B. The Department may:
   1. Review any of the following records in electronic or written format, as are applicable to the person or facility specified in subsection (A):
      a. Patient medical records;
      b. Medical records for the mother of a patient;
      c. Reports from:
         i. Physicians or other individuals who clinically evaluated, diagnosed, or treated a patient or the patient’s mother,
         ii. High-risk perinatal practices,
         iii. Prenatal diagnostic facilities,
         iv. Genetic testing facilities,
         v. Pathology laboratories, or
         vi. Other facilities or clinical laboratories that performed a test for a patient or the patient’s mother;
      d. Logs and registers containing information about surgical procedures, as specified in A.A.C. R9-10-214(A)(6) or A.A.C. R9-10-1709(A);
      e. Other logs that may contain information about a patient or the mother of a patient with a birth defect, such as:
         i. Labor and delivery unit logs,
         ii. Nursery unit logs,
         iii. Pediatric unit logs,
         iv. Intensive care unit logs,
         v. Autopsy logs, and
         vi. Ultrasound logs;
      f. Autopsy reports; and
      g. Records other than those specified in subsections (B)(1)(a) through (f) that contain information about or may lead to information about:
         i. A patient,
         ii. The patient’s mother, or
         iii. The patient’s biological sibling; and
   2. Collect the following information from a person or facility specified in subsection (A), as applicable to a patient or the mother of a patient:
      a. The name, address, and telephone number of the person or facility, or the identification number assigned by the Department to the person or facility;
      b. The date of first contact and the date of last contact;
      c. The date the patient was admitted to a hospital;
      d. The date the patient was discharged from a hospital;
      e. The dates the mother of the patient was admitted and discharged from a hospital for:
         i. The birth of the patient, or
         ii. Treatment related to a possible birth defect in the patient;
      f. The name and address of the hospital or other location in which the patient was born;
      g. The name and address of a hospital in which the patient or the mother of the patient was admitted for treatment related to a possible birth defect in the patient;
      h. The specific unit of a hospital that provided medical services to the patient or the patient’s mother;
      i. The medical record number of the patient or the patient’s mother;
      j. The patient’s name and any other name by which the patient is known;
      k. The names, addresses, and dates of birth of the patient’s parents;
      l. The name, address and telephone number of the patient’s guardian, if a parent of the patient does not have physical custody of the patient;
      m. The patient’s date of birth and hour of birth;
      n. The estimated date of confinement for the pregnancy resulting in the patient’s birth;
      o. The estimated gestational age, length, weight, and head circumference of the patient at birth;
p. The patient’s gender, race, and ethnicity;
q. The race and ethnicity of the patient’s biological mother and father;
r. The address of the patient’s mother at the time of the patient’s birth;
s. The address and telephone number of the patient at the date of last contact;
t. The county in which the patient was born;
u. The name of each physician, registered nurse practitioner, physician assistant, or other person that clinically evaluated, diagnosed, ordered a test for, or treated the patient or the patient’s mother;
v. The names of any facility from which or to which the patient or the patient’s mother was transferred or referred;
w. Whether the patient was referred to or is enrolled in CRS and, if so, the date of referral or enrollment;
x. Whether the patient is receiving any other follow-up services, medical services, nursing services, or health-related services related to a birth defect, and, if so, the name of the person providing the services and the date the provision of the services began;
y. The name of the insurance company, if applicable, that:
  i. Paid for the birth of the patient, and
  ii. Is currently covering medical expenses for the patient or the patient’s mother;
z. Any perinatal risk factors documented in:
  i. The patient’s medical record,
  ii. The patient’s mother’s medical record, or
  iii. The patient’s family medical history;
aa. Whether any tests were performed on the patient or the patient’s mother by a genetic testing facility and, if so:
  i. The types of tests performed,
  ii. The test dates,
  iii. The test results,
  iv. The age or estimated gestational age of the patient at the time of each test,
  v. The estimated date of confinement of the patient’s mother at the time of each test,
  vi. The name of the genetic testing facility that performed each test; and
  vii. The names of the individuals who interpreted the test results;
bb. Whether any tests were performed on the patient or the patient’s mother by a prenatal diagnostic facility and, if so:
  i. The types of tests performed,
  ii. The test dates,
  iii. The test results,
  iv. The age or estimated gestational age of the patient at the time of each test,
  v. The estimated date of confinement of the patient’s mother at the time of each test,
  vi. The name of the prenatal diagnostic facility that performed each test, and
  vii. The names of the individuals who interpreted the test results;
c. Whether any other types of tests were performed on the patient or the patient’s mother that may enable the diagnosis of a birth defect and, if so:
  i. The types of tests performed,
  ii. The test dates,
  iii. The test results,
  iv. The age or estimated gestational age of the patient at the time of each test,
  v. The estimated date of confinement of the patient’s mother at the time of each test,
  vi. The names of the facilities that performed the tests, and
  vii. The names of the individuals who interpreted the test results;
dd. Whether any surgical procedures associated with a birth defect were performed on the patient or the patient’s mother and, if so:
  i. The types of surgical procedures performed,
  ii. The dates of the surgical procedures,
  iii. The results of the surgical procedures,
  iv. The ages or estimated gestational ages of the patient at the time of the surgical procedures,
  v. The estimated date of confinement of the patient’s mother at the times of the surgical procedures, and
  vi. The names of the facilities at which the surgical procedures were performed, and
  vii. The names of the individuals who performed the surgical procedures;
cc. Whether any other types of tests were performed on the patient or the patient’s mother that may enable the diagnosis of a birth defect and, if so:
  i. The types of tests performed,
  ii. The test dates,
  iii. The test results,
The Department may request a hospital, high-risk perinatal practice, genetic testing facility, or prenatal diagnostic facility to revise a report:

1. That was submitted to the Department by the designee of the hospital, high-risk perinatal practice, genetic testing facility, or prenatal diagnostic facility under R9-4-502; and
2. That was not prepared according to R9-4-502; and
3. By identifying the revisions that are needed in the report.

If a person receives a request from the Department for revision of a report, the person shall return a revised report, containing the revisions requested by the Department, to the Department within 15 business days after the date of the Department’s request, or by a date agreed to by the person and the Department.

The Department may discuss the information submitted to the Department as specified in R9-4-502 or collected as specified in R9-4-503(B)(2) with any of the entities specified in R9-4-503(A) to obtain additional information about a patient’s diagnosis or treatment.

An ambulance service, an emergency medical services provider, or a law enforcement agency shall, either personally or through a representative, submit a report to the Department, in a Department-provided format and within five business days after an encounter with an individual with a suspected opioid overdose, that includes:

1. The following information about the ambulance service, emergency medical services provider, or law enforcement agency:
   a. Name;
   b. Street address, city, county, and zip code;
   c. Whether the entity reporting is:
      i. An ambulance service;
      ii. An emergency medical services provider, or
   iii. A law enforcement agency; and
   d. If applicable, the certificate number issued by the Department to the ambulance service;
2. The name, title, telephone number, and email address of a point of contact for the entity required to report;
3. The street address, city, county, state, and zip code of the location at which the ambulance service, emergency medical services provider, or law enforcement agency encountered the individual;
4. If applicable, the date and time the ambulance service, emergency medical services provider, or law enforcement agency was dispatched to the location specified according to subsection (A)(3);
5. The following information about the individual with a suspected opioid overdose or who died of a suspected opioid overdose:
   a. Name;
   b. Date of birth;
   c. Age in years,
   d. Gender,
   e. Race and ethnicity, and
   f. Reason for suspecting that the individual had an opioid overdose;
6. Whether naloxone was administered to the individual before the ambulance service, emergency medical services provider, or law enforcement agency encountered the individual and, if so:
   a. The number of doses of naloxone administered to the individual; and
   b. As applicable, that the naloxone was administered to the individual by:
      i. Another individual; or
      ii. Another entity and, if so the type of entity that administered the naloxone to the individual;
7. Whether naloxone was administered to the individual by the ambulance service, emergency medical services provider, or law enforcement agency and, if so, the number of doses of naloxone administered to the individual;
8. The following information about the disposition of the individual:

### Historical Note
New Section made by final rulemaking at 13 A.A.R. 1702, effective June 30, 2007 (Supp. 07-2).
a. Whether the individual was pronounced dead at the location specified according to subsection (A)(3); 
b. Whether the individual was transported to a hospital and; if so: 
   i. The name of the hospital to which the individual was transported, and 
   ii. The type of entity that transported the individual to the hospital; 
  c. If known, whether the individual: 
     i. Survived the suspected opioid overdose, 
     ii. Died from the suspected opioid overdose, or 
     iii. Died from another cause after experiencing a suspected opioid overdose; and 

9. The date of the report. 

B. An administrator of a health care institution licensed under 9 A.A.C. 10 or a pharmacist, as applicable, is not required to submit a report to the Department under this Article for: 

1. An opioid overdose resulting from the administration of the opioid to a patient in the health care institution if the opioid overdose is addressed through the health care institution’s quality management program; or 

2. Naloxone dispensed in connection with a surgical procedure, as defined in A.A.C. R9-10-101, performed in the health care institution. 

C. Except as prohibited by Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2 or as specified in subsection (B), a health professional or the administrator of a health care institution licensed under 9 A.A.C. 10 shall, either personally or through a representative, submit a report to the Department, in a Department-provided format and within five business days after an encounter with an individual with a suspected opioid overdose, that includes: 

1. The name, street address, city, county, zip code, and telephone number of the health professional or health care institution; 

2. If different from the person in subsection (C)(1), the name, title, street address, city, county, zip code, telephone number, and email address of the individual reporting on behalf of the person in subsection (C)(1); 

3. The following information about the individual with a suspected opioid overdose: 
   a. The individual’s name; 
   b. The individual’s street address, city, county, state, and zip code; 
   c. The individual’s date of birth; 
   d. The individual’s gender; 
   e. The individual’s race and ethnicity; 
   f. Whether the individual is pregnant and, if so, the expected date of delivery; 
   g. If applicable, the name of the individual’s guardian; and 
   h. Whether naloxone was administered to the individual before the health professional or health care institution encountered the individual and, if so: 
      i. The type of entity that administered the naloxone to the individual, or 
      ii. That the naloxone was administered to the individual by another individual; 

4. The following information about the diagnosis of opioid overdose: 
   a. The reason for suspecting that the individual had an opioid overdose; 
   b. The date of the suspected opioid overdose; 
   c. The date of diagnosis; and 
   d. Except as provided in subsection (G), if the diagnosis was confirmed through one or more tests performed by a clinical laboratory, for each test: 
      i. The name, address, and telephone number of the clinical laboratory; 
      ii. The date a specimen was collected from the individual; 
      iii. The type of specimen collected; 
      iv. The type of laboratory test performed; and 
      v. The laboratory test result and date of the result; 

5. The following information about the suspected opioid overdose: 
   a. Whether the opioid overdose appeared to be intentional or unintentional; 
   b. The location where the opioid overdose took place; 
   c. Whether the individual was alone at the time of the opioid overdose; 
   d. Whether the individual was transported to the health professional or health care institution by an ambulance service, an emergency medical services provider, or a law enforcement agency and, if so, the type of entity that transported the individual; 
   e. The specific opioid that appeared to be responsible for the opioid overdose; and 
   f. If known, whether: 
      i. The individual was prescribed an opioid within the 90 calendar days before the date of the suspected opioid overdose; 
      ii. The individual had been referred to receive behavioral health services, as defined in A.R.S. § 36-401; or 
      iii. The opioid overdose was the first time the individual had had an opioid overdose and, if not, the number of previous opioid overdoses the individual was known to have had; 

6. Whether the individual with the suspected opioid overdose: 
   a. Survived the suspected opioid overdose and: 
      i. Was admitted to the health care institution; 
      ii. Was transferred to another health care institution and, if so, the name of the health care institution; 
      iii. Was discharged to a law enforcement agency; 
      iv. Was discharged to home; or 
      iv. Left the health care institution against medical advice; 
   b. Died from the suspected opioid overdose and, if so, the date of death; or 
   c. Died from another cause after experiencing a suspected opioid overdose and, if so, the date of death; and 

7. The date of the report. 

D. Except as prohibited by Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2, a health professional or the administrator of a health care institution licensed under 9 A.A.C. 10 shall, either personally or through a representative, submit a report to the Department, in a Department-provided format and within five business days after an encounter with an individual with suspected neonatal abstinence syndrome, that includes: 

1. The name, street address, city, county, zip code, and telephone number of the health professional or health care institution; 

2. If different from the person in subsection (D)(1), the name, title, street address, city, county, zip code, tele-
1. The following information about the medical examiner:
   a. Name; and
   b. Street address, city, county, and zip code;

2. The following information about the deceased individual with a suspected opioid overdose:
   a. The deceased individual’s name;
   b. The deceased individual’s date of birth;
   c. The deceased individual’s gender;
   d. The deceased individual’s race and ethnicity;
   e. Whether the deceased individual was pregnant and, if so, the expected date of delivery;
   f. If applicable, the name of the deceased individual’s guardian; and
   g. Whether naloxone was administered to the deceased individual before the deceased individual’s death and, if known:
      i. The type of entity that administered the naloxone to the deceased individual, or
      ii. That the naloxone was administered to the deceased individual by another individual;

3. The following information about the diagnosis of opioid overdose:
   a. The reason for suspecting that the deceased individual had an opioid overdose;
   b. The date of the opioid overdose;
   c. The date of diagnosis; and
   d. If the diagnosis was confirmed by clinical laboratory tests:
      i. The name, address, and telephone number of the clinical laboratory;
      ii. The date a specimen was collected from the deceased individual;
      iii. The type of specimen collected;
      iv. The type of laboratory test performed; and
      v. The laboratory test result and date of the result; and
   e. Whether any of the following supported a diagnosis of neonatal abstinence syndrome:
      i. A maternal history of opioid use,
      ii. A positive laboratory test for opioid use by the individual’s mother, or
      iii. A positive laboratory test for opioids in the individual;
   f. Whether the deceased individual was alone at the time of the opioid overdose;
   g. The deceased individual’s date of birth;
   h. The deceased individual’s gender;
   i. The deceased individual’s race and ethnicity;

4. If applicable, a copy of the clinical laboratory test results;

5. If known, the following information about the suspected opioid overdose:
   a. Whether the opioid overdose appeared to be intentional or unintentional;
   b. The location where the opioid overdose took place;
   c. Whether the deceased individual was alone at the time of the opioid overdose;
   d. The specific opioid that appeared to be responsible for the opioid overdose;
   e. Whether the deceased individual was prescribed an opioid within the 90 calendar days before the date of the opioid overdose; and
   f. Whether the opioid overdose was the first time the deceased individual was known to have had an opioid overdose and, if not, the number of previous opioid overdoses the deceased individual had had;

6. Whether the deceased individual with the suspected opioid overdose:
   a. Died from the suspected opioid overdose and, if so, the date of death; or
   b. Died from another cause after experiencing a suspected opioid overdose and, if so, the date of death; and

7. The date of the report.

A director of a clinical laboratory, on the premises of a health care institution licensed as a hospital, as defined in A.A.C. R9-10-101, or performing laboratory tests under an arrangement with a hospital, shall submit a report to the Department, in a Department-provided format and within five business days after completing laboratory tests on one or more specimens

phone number, and email address of the individual reporting on behalf of the person in subsection (D)(1);

3. The following information about the individual with suspected neonatal abstinence syndrome:
   a. The individual’s name;
   b. The individual’s date of birth;
   c. The individual’s gender;
   d. The individual’s race and ethnicity;
   e. The name of the individual’s mother; and
   f. If not the individual’s mother, the name of the individual’s guardian;

4. The following information about a diagnosis of neonatal abstinence syndrome:
   a. The reason for suspecting that the individual has neonatal abstinence syndrome;
   b. The date of the onset of signs of neonatal abstinence syndrome;
   c. The date of diagnosis;
   d. Except as provided in subsection (G), if the diagnosis was confirmed through one or more tests performed by a clinical laboratory, for each test:
      i. The name, address, and telephone number of the clinical laboratory;
      ii. The date a specimen was collected from the individual;
      iii. The type of specimen collected;
      iv. The type of laboratory test performed; and
      v. The laboratory test result and date of the result; and
   e. Whether any of the following supported a diagnosis of neonatal abstinence syndrome:
      i. A maternal history of opioid use,
      ii. A positive laboratory test for opioid use by the individual’s mother, or
      iii. A positive laboratory test for opioids in the individual;
   f. Whether the deceased individual was known to have had an opioid overdose;
   g. Whether naloxone was administered to the deceased individual before the deceased individual’s death and, if known:
      i. The type of entity that administered the naloxone to the deceased individual, or
      ii. That the naloxone was administered to the deceased individual by another individual;

5. If known, the following information about the suspected neonatal abstinence syndrome:
   a. The source of the opioid believed to have caused the neonatal abstinence syndrome; and
   b. If the source of the opioid used by the individual’s mother was not through a prescription order, as defined in A.R.S. § 32-1901, the specific opioid used by the individual’s mother; and

6. The date of the report.

E. Except as specified in subsection (B), a pharmacist shall, either personally or through a representative, submit a report to the Department, in a format provided by the Arizona Board of Pharmacy and within five business days after dispensing naloxone to an individual, that includes:

1. The following information about the pharmacist:
   a. Name;
   b. Pharmacy street address, city, county, and zip code; and
   c. The professional license number issued to the pharmacist under A.R.S. Title 32;

2. The number of doses of naloxone dispensed to the individual by the pharmacist;

3. The date the naloxone was dispensed; and

4. The date of the report.

F. A medical examiner shall, either personally or through a representative, submit a report to the Department, in a Department-provided format and within five business days after the completion of the death investigation required in A.R.S. § 11-594 on the human remains of a deceased individual with a suspected opioid overdose, that includes:

1. The following information about the medical examiner:
   a. Name; and
   b. Street address, city, county, and zip code;

2. The following information about the deceased individual with a suspected opioid overdose:
   a. The deceased individual’s name;
   b. The deceased individual’s date of birth;
   c. The deceased individual’s gender;
   d. The deceased individual’s race and ethnicity;
   e. Whether the deceased individual was pregnant and, if so, the expected date of delivery;
   f. If applicable, the name of the deceased individual’s guardian; and
   g. Whether naloxone was administered to the deceased individual before the deceased individual’s death and, if known:
      i. The type of entity that administered the naloxone to the deceased individual, or
      ii. That the naloxone was administered to the deceased individual by another individual;

3. The following information about the diagnosis of opioid overdose:
   a. The reason for suspecting that the deceased individual had an opioid overdose;
   b. The date of the opioid overdose;
   c. The date of diagnosis; and
   d. If the diagnosis was confirmed by clinical laboratory tests:
      i. The name, address, and telephone number of the clinical laboratory;
      ii. The date a specimen was collected from the deceased individual;
      iii. The type of specimen collected;
      iv. The type of laboratory test performed; and
      v. The laboratory test result and date of the result; and
   e. Whether any of the following supported a diagnosis of neonatal abstinence syndrome:
      i. A maternal history of opioid use,
      ii. A positive laboratory test for opioid use by the individual’s mother, or
      iii. A positive laboratory test for opioids in the individual;
   f. Whether the deceased individual was alone at the time of the opioid overdose;
   g. The deceased individual’s date of birth;
   h. The deceased individual’s gender;
   i. The deceased individual’s race and ethnicity;

4. If applicable, a copy of the clinical laboratory test results;

5. If known, the following information about the suspected opioid overdose:
   a. Whether the opioid overdose appeared to be intentional or unintentional;
   b. The location where the opioid overdose took place;
   c. Whether the deceased individual was alone at the time of the opioid overdose;
   d. The specific opioid that appeared to be responsible for the opioid overdose;
   e. Whether the deceased individual was prescribed an opioid within the 90 calendar days before the date of the opioid overdose; and
   f. Whether the opioid overdose was the first time the deceased individual was known to have had an opioid overdose and, if not, the number of previous opioid overdoses the deceased individual had had;

6. Whether the deceased individual with the suspected opioid overdose:
   a. Died from the suspected opioid overdose and, if so, the date of death; or
   b. Died from another cause after experiencing a suspected opioid overdose and, if so, the date of death; and

7. The date of the report.
from an individual that indicate a positive result for the presence of an opioid or an opioid metabolite, that includes:

1. The name and address of the clinical laboratory;
2. The name and telephone number of the director of the clinical laboratory;
3. The name and, if available, the address of the individual;
4. The date of birth of the individual;
5. The gender of the individual;
6. The laboratory identification number;
7. For each laboratory test performed:
   a. The date of collection of the specimen;
   b. The type of specimen collected;
   c. The type of laboratory test performed on the specimen;
   d. The laboratory test result, including quantitative values and reference ranges, if applicable; and
   e. The date of the laboratory test result; and
8. The date of the report.

II. Information collected on individuals pursuant to this Article is confidential, subject to disclosure provisions in A.R.S. Title 12, Chapter 13, Article 7.1, and 9 A.A.C. 1, Article 3.

**Historical Note**
New Section made by emergency rulemaking at 23 A.A.R. 2857, effective September 21, 2017, for 180 days (Supp. 17-3).