RULES
OF
THE DEPARTMENT OF COMMERCE AND INSURANCE
DIVISION OF INSURANCE

CHAPTER 0780-01-79
UNIFORM REPORTING SYSTEM FOR THE ALL PAYER CLAIMS DATABASE

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0780-01-79-.01 PURPOSE AND SCOPE.

This Chapter contains the provisions for submission of health care claims data sets by health insurance issuers.

Authority: *2009 Public Acts, Chapter 611 and T.C.A. § 56-2-125.* ***Administrative History:*** *Emergency rule filed March 11, 2010; effective through September 7, 2010. Original rule filed June 10, 2010; effective September 8, 2010.*

0780-01-79-.02 DEFINITIONS.

Unless the context indicates otherwise, the following words and phrases shall have the following meanings:

(1) "Address" means street address, post office box numbers, apartment numbers, e-mail addresses, web universal resource locator (URL) and internet protocol (IP) address number.

(2) "Capitated services" means services rendered by a provider through a contract in which payments are based upon a fixed dollar amount for each member on a monthly basis.

(3) "Commissioner" means the commissioner of the Tennessee Department of Commerce and Insurance.

(4) “Comprehensive medical insurance policy” means an insurance policy covering all that a defined population might reasonably require in order to be in good health, including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, ambulatory physician care and outpatient preventative medical services.

(5) "Department" means the Tennessee Department of Commerce and Insurance.

(6) "Designee" means an entity with which the Department and/or the department of finance and administration have entered into an arrangement pursuant to which the entity performs data management and collecting functions, and under which the entity is strictly prohibited from using or releasing the information and data obtained in such a capacity for any purposes other than those specified in the agreement.

(7) "Direct identifier" means any information, other than case or code numbers used to create anonymous or encrypted data, that plainly discloses the identity of an individual, including:

(a) Patient names;

(Rule 0780-01-79-.02, continued)

(b) Patient Street addresses other than town or city, state and zip code;

(c) All elements of patient birth dates, except year of birth;

(d) Patient telephone numbers;

(e) Patient facsimile numbers;

(f) Patient electronic mail addresses;

(g) Patient social security numbers;

(h) Medical record numbers;

(i) Health Plan beneficiary numbers;

(j) Patient account numbers;

(k) Patient certificate/license numbers;

(l) Vehicle identifiers and serial numbers including license plates;

(m) Device identifiers and serial numbers;

(n) Web universal resource locators (URLs);

(o) Internet protocol (IP) address numbers;

(p) Biometric identifiers, including fingerprints, voice prints, and genetic code;

(q) Full-face photographic images and any comparable images; or

(r) Any other unique patient identifying number, characteristic, or code except encrypted index numbers assigned prior to the transmission by health insurance issuers to the state or designated entity for the purpose of linking procedures by patient, provided a patient's identity cannot be known from the encrypted index number.

(8) "Group health plan" means an employee welfare benefit plan, as defined in the Employee Retirement Income Security Act of 1974 ("ERISA") § 3(1), codified in 29 U.S.C. § 1002(1), to the extent that the plan provides medical care to employees or their dependents, as defined under the terms of the plan, or an administrator of such a plan. For purposes of this rule, "group health plan" shall not mean any plan which is offered through a health insurance issuer;

(9) "Health care claims data" means information consisting of, or derived directly from, member eligibility files, medical claims files, and pharmacy claims files submitted by health insurance issuers.

(10) "Health care practitioner" means physicians and all others certified, registered or licensed in the healing arts, including, but not limited to:

(a) Nurses;

(b) Advanced practice nurses

(Rule 0780-01-79-.02, continued)

(c) Podiatrists;

(d) Optometrists;

(e) Pharmacists;

(f) Chiropractors;

(g) Physical therapists;

(h) Psychologists; and

(i) Physicians' assistants.

(11) “Health insurance issuer” means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including but not limited to, an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation. In addition, a “health insurance issuer” also means a pharmacy benefits manager, a third party administrator, and an entity described in § 56-2-121.

(12) "Hospital" means a licensed acute or specialty care institution.

(13) "Medical claims file" means a data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to:

(a) Member demographics;

(b) Provider information;

(c) Charge/payment information; and

(d) Clinical diagnosis/procedure codes.

(14) "Member" means the subscriber and any spouse and/or dependent who is covered by the subscriber's policy.

(15) "Member eligibility file" means a data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month.

(16) “Pharmacy benefits manager” means a person, business or other entity and any wholly or partially owned subsidiary of the entity, that administers the medication and/or device portion of pharmacy benefits coverage.

(17) "Pharmacy claims file" means a data file containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to:

(a) Member demographics;

(b) Provider information;

(c) Charge/payment information; and

(Rule 0780-01-79-.02, continued)

(d) National drug codes.

(18) "Plan sponsor" means any person, other than an insurer, who establishes or maintains a plan covering residents of the state of Tennessee, including, but not limited to, plans established or maintained by employers or jointly by one or more employers and one or more employee organizations, committee, joint board of trustees or other similar group of representatives of the parties that establish or maintain the plan.

(19) "Provider" means a health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy.

(20) “Sub-contractor” means any entity that contracts with a group health plan or health insurance issuer to provide insurance services.

(21) "Subscriber" means the certificate holder.

(22) “Third party administrator” means an entity that, on behalf of a health insurance issuer, employer or other entity, provides health benefits coverage or health insurance coverage, as defined in T.C.A. § 56-2-125(a)(5), to individuals in this state, receives or collects charges, contributions or premiums for, or adjudicates, processes or settles claims in connection with, any type of health benefit provided in, or as an alternative to, health insurance coverage.

Authority: *2009 Public Acts, Chapter 611 and T.C.A. § 56-2-125.* ***Administrative History:*** *Emergency rule filed March 11, 2010; effective through September 7, 2010. Original rule filed June 10, 2010; effective September 8, 2010.*

0780-01-79-.03 HEALTH CARE CLAIMS DATA SET FILING DESCRIPTION.

(1) Beginning on June 1, 2010, and continuing thereafter in accordance with the submission schedule set forth in Rule 0780-01-79-.05, each health insurance issuer shall submit to the Department, or its designee, a completed health care claims data set for all residents of Tennessee. Each health insurance issuer shall also submit all health care claims processed by any sub-contractor on its behalf. The health care claims data set shall include member eligibility files (for the pharmacy benefit and the medical benefit), a medical claims file, and a pharmacy claims file.

(2) The Department, or its designee, shall provide a phone number, e-mail address and mailing address of a contact person who can provide information on the status of data files submitted.

(3) The Department will prepare the All Payer Claims Database Procedure Manual that will list the variables to be reported, their descriptions and reporting format, the thresholds required for a submission to be deemed complete, the method for sending data, and other information associated with data submission. The Department shall make future changes in the Procedure Manual when the Commissioner deems changes to be necessary. Reporting entities will be notified in writing by the Department of all revisions. These revisions become effective one hundred and eighty (180) calendar days following the date of written notification. At that time, failure to meet the amended requirements are subject to the penalties as prescribed by T.C.A. § 56-2-125.

(4) The minimum data set for each reported member eligibility file will include the following elements, except as otherwise set forth in the All Payer Claims Database Procedure Manual:

(a) Eligibility;

(Rule 0780-01-79-.03, continued)

(b) Type of insurance;

(c) Coverage type;

(d) Encrypted index numbers for linking procedures by patient;

(e) Member's relationship to subscriber;

(f) Member gender;

(g) Member year of birth;

(h) Member age in months; and

(i) Member city, state, and zip code of residence.

(5) The minimum data set for each reported medical claims file will include the following elements, except as otherwise set forth in the All Payer Claims Database Procedure Manual:

(a) National Plan ID;

(b) Insurance type;

(c) Payer claim control number;

(d) Claim line counter;

(e) Insured group or policy number for non-individual groups;

(f) Encrypted index numbers for linking procedures by patient;

(g) Member's relationship to subscriber;

(h) Member gender;

(i) Member year of birth;

(j) Member age in months;

(k) Member city, state, and zip code of residence;

(l) Paid date;

(m) Admission time and date;

(n) Admission type;

(o) Source of admission;

(p) Discharge hour;

(q) Discharge status;

(r) Service provider number;

(Rule 0780-01-79-.03, continued)

(s) Service provider tax ID;

(t) National service provider ID;

(u) Type of service provider;

(v) Service provider name;

(w) Service provider specialty;

(x) Service provider address;

(y) Type of bill;

(z) Place of service;

(aa) Claim status;

(bb) Admitting diagnosis;

(cc) E-code;

(dd) Principal diagnosis;

(ee) Other diagnoses;

(ff) Onset of diagnosis code;

(gg) Revenue code;

(hh) ICD-9-CM procedure codes;

(ii) Current claims terminology;

(jj) Health care common procedural coding system;

(kk) Dates of service;

(ll) Quantity of services performed;

(mm) Charge amount;

(nn) Paid amount;

(oo) Prepaid amount;

(pp) Copay amount;

(qq) Coinsurance amount;

(rr) Deductible amount;

(ss) DRG and version number;

(tt) APC and version number;

(Rule 0780-01-79-.03, continued)

(uu) Drug code;

(vv) Billing provider number; and

(ww) Billing provider name.

(6) The minimum data set for each reported pharmacy claims file will include the following elements, except as otherwise set forth in the All Payer Claims Database Procedure Manual:

(a) National Plan ID;

(b) Insurance type;

(c) Payer claim control number;

(d) Claim line counter;

(e) Insured group or policy number;

(f) Encrypted index numbers for linking procedures by patient;

(g) Member's relationship to subscriber;

(h) Member gender;

(i) Member year of birth;

(j) Member age in months;

(k) Member city, state, and zip code of residence;

(l) Date service approved;

(m) Pharmacy number;

(n) Pharmacy Tax ID;

(o) Pharmacy country code;

(p) Claims status;

(q) Drug code;

(r) Drug name;

(s) New prescription or refill;

(t) Generic drug indicator;

(u) Dispense as written code;

(v) Compound drug indicator;

(w) Date prescription filled;

(Rule 0780-01-79-.03, continued)

(x) Quantity dispensed;

(y) Days of supply;

(z) Gross amount due;

(aa) Total amount paid;

(bb) Ingredient cost/list price;

(cc) Postage amount claimed;

(dd) Dispensing fee paid;

(ee) Copay;

(ff) Coinsurance amount;

(gg) Prescribing physician name; and

(hh) Prescribing physician number.

(7) The Department, or its designee, shall also provide an electronic newsletter or other method of communicating information to health insurance issuers regarding the receipt, processing and loading of data files.

(8) Health insurance issuers that are not pharmacy benefits managers and that paid a total of less than $5,000,000 for covered residents of Tennessee during the previous calendar year shall not be required to submit their health care claims data set. In calculating its paid claims, each health insurance issuer must include all health care claims for covered individuals processed by any subcontractor on its behalf.

(9) Pharmacy benefit managers that paid a total of less than $1,000,000 for covered residents of Tennessee during the previous calendar year shall not be required to submit their health care claims data set. In calculating its paid claims, each pharmacy benefits manager must include all health care claims for covered individuals processed by any subcontractor on its behalf.

(10) In instances where more than one entity is involved in the administration of a policy, the health insurance issuer responsible for submitting the claims data on policies shall be the one that has written the policies.

(11) The Department may enter into an agreement with a third party designee to collect and process the data. The agreement shall provide that the third party designee shall be strictly prohibited from collecting direct identifiers and from releasing or using data or information obtained in its capacity as a collector and processor of the data for any purposes other than those specifically authorized by the agreement.

Authority: *2009 Public Acts, Chapter 611 and T.C.A. § 56-2-125.* ***Administrative History:*** *Emergency rule filed March 11, 2010; effective through September 7, 2010. Original rule filed June 10, 2010; effective September 8, 2010.*

0780-01-79-.04 GENERAL REQUIREMENTS FOR HEALTH CARE CLAIMS DATA SUBMISSION.

(1) Capitated services claims. Claims for capitated services shall be reported with all medical and pharmacy file submissions.

(2) Claim records. Records for medical and pharmacy claims file submissions shall be reported at the visit, service, or prescription level. The submission of the medical and pharmacy claims shall be based upon the paid dates and not upon the dates of service associated with the claims.

(3) Specific/Unique Coding. With the exception of provider codes and provider specialty codes, specific or unique coding systems shall not be permitted as part of the health care claims data set submission.

(4) Medical Claims File Exclusions. Claims for stand-alone insurance policies shall be excluded if the stand-alone coverage is provided for the following types of services:

(a) Specific disease;

(b) Accident;

(c) Injury;

(d) Hospital indemnity;

(e) Disability;

(f) Long-term care;

(g) Vision coverage; or

(h) Durable medical equipment.

(5) Claims for the types of services in (4) above shall be included in the medical claims file submission if they are covered by a comprehensive medical insurance policy.

(6) Behavioral or Mental Health Claims. All claims related to behavioral, mental health, or substance abuse treatment shall be included in the medical claims file**.**

(7) Claims related to Medicare supplemental, TRICARE supplemental, or other supplemental health insurance policies are to be excluded if the plan of benefits are not considered to be primary. If the policies cover health care services entirely excluded by the Medicare, TRICARE, or other program, the claims must be submitted.

(8) Member Eligibility File Exclusions. Members without medical and/or pharmacy coverage during the month reported shall be excluded.

(9) Pharmacy Claims File Exclusions. Claims for pharmacy services generated from non-retail pharmacies that do not contain national drug codes shall be included in the following files:

(a) If the pharmacy claims are covered under the medical benefit they shall be included in the medical claims file and not the pharmacy claims file;

(b) If the claim is covered under the prescription benefit then the claim shall be included in the pharmacy claims file;

(Rule 0780-01-79-.04, continued)

(c) If the claims are submitted as standard UB04, NSF, or ANSI 935 formatted transactions without NDC codes, the claim shall be included in the medical claims file.

(10) Registration Form.

(a) Each health insurance issuer, whether they are subject to the reporting requirements of Rule 0780-01-79-.05 or not, shall submit an annual registration form to the Department, or the Department's designee, every year by July 1. The form shall be in the format approved by the Commissioner.

(b) At a minimum, the form shall contain the following information:

1. Company name;

2. NAIC code;

3. Mailing address;

4. Information about whether the company conducts health insurance-related business;

5. Number of Tennessee members covered;

6 The total amount paid by the health insurance issuer during the year on covered lives in Tennessee; and,

7. Name, e-mail address and address of the person completing the form.

(c) Health insurance issuers shall submit a registration form by April 1, 2010, and annually thereafter.

(11) No health insurance issuer shall replace a complete data file submission more than one year after the end of the month in which the file was submitted unless it can establish exceptional circumstances for the replacement. Any replacements after this period shall be approved by the Department. Individual adjustment records shall be submitted with a monthly data file submission.

Authority: *2009 Public Acts, Chapter 611, T.C.A. §§ 56-2-125 and 56-2-301.* ***Administrative History:*** *Emergency rule filed March 11, 2010; effective through September 7, 2010. Original rule filed June 10, 2010; effective September 8, 2010.*

0780-01-79-.05 SUBMISSION SCHEDULE.

(1) Health insurance issuers shall report historical health care claims data according to the following schedule:

Time Span	Submission Due Date
January 1-31, 2009	June 1, 2010
February 1 – June 30, 2009	July 1, 2010
July 1, 2009 – September 30, 2010	November 1, 2010

(2) Once each health insurance issuer has completed submitting historical health care claims data, it shall submit health care claims data monthly. Submissions are due on the first day of

(Rule 0780-01-79-.05, continued)

the month for health care claims data covering the time span of the month preceding the prior month, or according to the following schedule:

Time Span	Submission Due Date
October	December 1
November	January 1
December	February 1
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1
August	October 1
September	November 1

(3) The commissioner, in the commissioner's discretion, may allow some health insurance issuers to submit data on a quarterly basis.

(4) Group health plans shall be exempt from the data reporting requirements of T.C.A. § 56-2-125 and this rule to the extent that they do not use heath insurance issuers to administer health benefits. However, such group health plans may submit data in accordance with this rule.

Authority: *2009 Public Acts, Chapter 611, T.C.A. §§ 56-2-125 and 56-2-301.* ***Administrative History:*** *Emergency rule filed March 11, 2010; effective through September 7, 2010. Original rule filed June 10, 2010; effective September 8, 2010.*

0780-01-79-.06 COMPLIANCE WITH DATA STANDARDS AND PENALTIES FOR NON-COMPLIANCE.

(1) Compliance.

(a) Health insurance issuers shall make every effort to report the data fields as described in the Procedure Manual if the data field is present in any part of their data systems. Health insurance issuers shall submit data fields even in circumstances where the data is integrated from multiple systems. The Procedure Manual shall include minimum thresholds for submissions to be considered complete.

(b) The Department, or its designee, shall evaluate each member eligibility file, medical claims file and pharmacy claims file to determine compliance with the Procedure Manual.

(c) Upon completion of the evaluation, the Department or its designee shall promptly notify each health insurance issuer whether its data submissions satisfy the standards. This notification shall identify the specific file and the data elements that do not satisfy the standards.

(d) Each health insurance issuer notified of a non-compliant data submission shall respond within 10 business days of the notification by making the changes necessary to satisfy the standards.

(2) Penalties for Non-Compliance.

(Rule 0780-01-79-.06, continued)

(a) The Department may assess a civil penalty of up to one hundred dollars ($100.00) per day for delinquent claims submissions.

(b) Failure to conform to the requirements for submission shall result in the rejection of the applicable data file(s). All rejected files shall be resubmitted in the appropriate, corrected form to the Department, or their designee, within 10 business days. The Department may assess a civil penalty of up to one hundred dollars ($100.00) per day for rejected files not resubmitted within 10 business days.

(c) The Commissioner has the authority to delay, reduce, or waive any penalty for not correcting any particular data element if:

1. Correcting the failure would be excessively onerous for the health insurance issuer on technical grounds such as: the health insurance issuer does not gather the particular data element or does not store the particular data element;

2. The health insurance issuer is working diligently, in the Commissioner's judgment, to correct the failure; or,

3. The failure to correct is due to force majeure or other events of extraordinary circumstances clearly beyond the control of the health insurance issuer.

Authority: *2009 Public Acts, Chapter 611, T.C.A. §§ 56-2-125 and 56-2-301.* ***Administrative History:*** *Emergency rule filed March 11, 2010; effective through September 7, 2010. Original rule filed June 10, 2010; effective September 8, 2010.*

0780-01-79-.07 SEVERABILITY PROVISION.

If any Rule or portion of a Rule of this Chapter or its applicability to any person or circumstance is held invalid by a court, the remainder of the Chapter or the applicability of the provision to other persons or circumstances shall not be affected. To this end, the provisions of this chapter are declared severable.

Authority: *2009 Public Acts, Chapter 611, T.C.A. §§ 56-2-125 and 56-2-301.* ***Administrative History:*** *Emergency rule filed March 11, 2010; effective through September 7, 2010. Original rule filed June 10, 2010; effective September 8, 2010.*