

**TENNESSEE DEPARTMENT OF HEALTH - 1200  
OFFICE OF POLICY, PLANNING AND ASSESSMENT  
HEALTH STATISTICS**

There will be a hearing before the Tennessee Department of Health, Office of Policy, Planning and Assessment, Health Statistics to consider the promulgation of new rules pursuant to T.C.A. §§ 4-5-202, 4-5-204 and 68-1-108. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Tennessee Room on the Ground Floor of the Cordell Hull Building, located at 425 5<sup>th</sup> Avenue North, Nashville, Tennessee at 9:00 a.m. C.S.T. on the 19<sup>th</sup> day of May, 2005.

Any individuals with disabilities who wish to participate in these proceedings (review these filings) should contact the Department of Health, Office of Policy, Planning and Assessment to discuss any auxiliary aids or services needed to facilitate such participation or review. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date such party intends to review such filings), to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the ADA Coordinator at the Department of Health, Office of Policy, Planning and Assessment, at the following address and/or phone number:

Charlotte Jones, 6<sup>th</sup> Floor Cordell Hull Building, 425 5th Avenue North, Nashville, TN 37247-5262, 741-0352.

For a copy of the entire text of this notice of rulemaking hearing contact: Marguerite Lewis, 4<sup>th</sup> Floor, Cordell Hull Building, 425 5th Avenue North, Nashville, TN, 37247-5262, (615) 532-6566

**SUBSTANCE OF PROPOSED RULES**

**AMENDMENTS**

The Table of Contents is amended to reflect the catchlines of the original rules and by deleting rule 1200-7-3-.08, which as amended shall read as follows:

**TABLE OF CONTENTS**

1200-7-3-.01	Definitions	1200-7-3-.05	Processing and Verification
1200-7-3-.02	Required Data Elements	1200-7-3-.06	Data Availability
1200-7-3-.03	Submission Time Line	1200-7-3-.07	Confidential Information
1200-7-3-.04	Penalty Assessment		

Rule 1200-7-3-.01 Definitions, is amended by deleting the language of paragraphs (1) through (12) and substituting instead the following:

- (1) "Aggregate Data" is defined as a set of multiple data records that are tabulated, combined, or otherwise summarized for the purpose of describing characteristics of a group of patient discharges.
- (2) "Department" is defined as the Department of Health.
- (3) "Discharge" shall be defined as the formal release of a patient from a hospital in either an inpatient or outpatient situation.
- (4) "Error" is defined as data that are incomplete or inconsistent with the specifications in T.C.A. 68-1-108, these rules, and the Hospital Discharge Data System Procedure Manual.

- (5) “Final Joint Annual Report” is defined as the most recent Joint Annual Report filed by a hospital where the data contained therein has been edited, queried and updated by the Department.
- (6) “Hospital” shall be defined as in T.C.A. 68-11-201(21)
- (7) “Inpatient” shall be defined as a person receiving reception and care in a hospital for a continuous period of twenty-four (24) hours or more for the purpose of giving advice, diagnosis, nursing service, or treatment bearing on the physical health of the person, and a person receiving maternity care involving labor and delivery for any period of time.
- (8) “Outpatient” shall be defined as a person receiving reception and care in a hospital for a continuous period less than twenty-four (24) hours for the purpose of giving advice, diagnosis, nursing service, or treatment bearing on the physical health of the person, excluding persons receiving maternity care involving labor and delivery. Reportable outpatient records are defined in the hospital discharge data system manual. Reportable records are defined in terms of the type of service provided and the type of bill on Form UB-92.
- (9) “Patient Identifiers” shall be defined to include the following data elements: Patient Control Number, Medical/Health Record Number, Certificate Number/ID Number/SSN, and Patient’s Social Security Number.
- (10) “Processed Data” is defined as data that have been reviewed by the Department for the purpose of detecting errors, inconsistencies, and/or incomplete elements in the data set
- (11) “Public” shall be defined as anyone other than the THA and agencies of the government of the State of Tennessee.
- (12) “Record Level Data” is defined as a set of data that is specific to a single patient discharge.
- (13) “THA” shall be defined as the administrative offices and staff of the Tennessee Hospital Association.
- (14) “UB-92” is defined to be CMS Form 1450, the Uniform Hospital Billing Form, or a successor form as established by the National Committee and the State Uniform Billing Implementation Committee.
- (15) “Verified Data” is defined as data that have been processed by the Department; the health facilities have had the opportunity to suggest corrections, additions, and/or deletions; and all appropriate revisions have been made to the data by the Department.

**Authority:** T.C.A. §§ 4-5-202, 4-5-204 68-1-108 and 68-11-201.

Rule 1200-7-3-.02 Required Data Elements, is amended by deleting paragraphs (1), (4), (5), (6) and (7) and substituting the following:

- (1) The Department will prepare the Hospital Discharge Data System (HDDS) Procedure Manual that will list the variables to be reported, their descriptions and reporting format, 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 by the Department of all revisions. These revisions become effective one hundred and eighty (180) days following the date of notification. At that time, failure to meet the amended requirements are subject to the penalties as prescribed by T.C.A. §68-1-108.
- (4) Reporting of all emergency room discharges will be required with emergency room discharges defined as those discharges having a revenue code of 0450 through 0459 inclusive in any revenue code field.

- (5) Required reporting of outpatient discharges are as follows.
  - (a) All outpatient discharges which have a revenue code of 0760, 0762, or 0769 in any revenue code field.
  - (b) All outpatient discharges with an ICD-9-CM procedure code in the range of 00.01 through 86.99 inclusive in any procedure code field.
  - (c) All outpatient discharges with a revenue code of 079X, 0404, 061X, 0333, or 035X in any revenue field also having a bill type of 12X, 13X, 14X, 7XX, 83X, or 85X, where “X” represents any numeric digit.
- (6) All data elements reported by the hospital should be the actual values used by the hospital. None should be encrypted or otherwise altered.
- (7) All hospitals which are required to report data by T.C.A. §68-1-108 shall designate one staff member to be responsible for reporting the claims data. The Department shall be notified by the hospital, on a form supplied by the Department, with the name, title, work address, and work telephone number of the designated staff member.

**Authority:** T.C.A. §§4-5-202, 4-5-204 and 68-1-108.

Rule 1200-7-3-.03 Submission Time Line, is amended by deleting paragraphs (1) through (4) and substituting instead the following new paragraphs (1) and (2):

- (1) All required data must be received by the Department each quarter according to the following schedule:

Quarter	Time Span	Submission Due Date
Q1	January 1 – March 31	May 30
Q2	April 1 – June 30	August 29
Q3	July 1 – September 30	November 29
Q4	October 1 – December 31	March 1

- (2) All data submissions must be in the form of computer media (e.g., magnetic tape, diskettes).

**Authority:** T.C.A. §§4-5-202, 4-5-204 and 68-1-108.

Rule 1200-7-3-.04 Penalty Assessment, is amended by deleting paragraphs (3) through (13) and substituting instead the following new paragraphs (3) through (12):

- (3) For hospitals not submitting any discharge reports by the submission deadline, the number of inpatient hospital discharge reports delinquent for a particular facility per quarter will be estimated by dividing the number of total inpatient discharges/or admissions reported in Schedule G of the most current, final Joint Annual Report of Hospitals (JAR-H) on file with the Department for that facility by four (4).

## Rulemaking Hearings

The number of delinquent outpatient claims reports for a quarter will likewise be estimated using data from the facility's most recent, final Joint Annual Report. This estimate will be obtained by dividing by four (4) the sum of outpatient data from Schedule D for percutaneous lithotripsy procedures, adult and pediatric cardiac catheterizations, adult and pediatric percutaneous transluminal coronary angioplasties, outpatient surgery procedures from dedicated O. R.'s and from procedure rooms, eye, bone, bone marrow, connective, cardiovascular, stem cell, and other transplants, and from Schedule I, total emergency room visits. The sum of the inpatient estimate and the outpatient estimate will be used to calculate the penalty assessed. Any positive or negative adjustments to the final estimate, up to a maximum of ten (10) percent will be made once the actual claims reports are received by the Department.

- (4) Hospitals not submitting any discharge reports by the submission deadline will begin accruing penalties starting the day immediately following the submission deadline and ending the day when the actual discharge reports are received by the Department or the maximum penalty is reached (maximum=\$10/discharge record).
- (5) For all 2006 discharges, the allowable error rate will be no more than 3%. For all discharges in 2007 and subsequent years, the allowable error rate will be no more than 2%. Records that fall within the acceptable rate will not be subject to any penalties. Hospitals that exceed the acceptable error rate will be penalized based on total errors.
- (6) Hospitals which do not submit corrected discharge records within the additional fifteen (15) days allocated for error correction will accrue delinquent penalties starting the sixteenth day after error notification and ending the day when the actual corrected discharge reports are received by the Department or the maximum penalty is reached (maximum=\$10/discharge record). The Commissioner has the authority to delay any penalty for not correcting any particular data element if the failure to correct is due to force majeure or other events of extraordinary circumstances clearly beyond the control of the hospital.
- (7) Upon receipt of the penalty assessment, the hospital has the right to an informal conference with the Commissioner. A written request for an informal conference must be received by the Commissioner within thirty (30) days of the assessment.
- (8) A notice of an approximate daily assessment of the civil penalty will be sent to the delinquent hospital(s). The assessment will estimate the approximate penalty per day based on the estimated number of discharge reports. The assessment will state that penalties will accrue until the delinquent discharge reports are received or the maximum penalty is reached. Delinquent penalties will be collected starting thirty (30) days from the date of notice and continuing every thirty days until the maximum penalty is reached or the discharge reports are received.
- (9) Penalties continue to accumulate for hospitals requesting an informal conference with the Commissioner.
- (10) The Commissioner can grant a waiver from penalties to a hospital in cases of force majeure or other events of extraordinary circumstances clearly beyond the control of the hospital. The hospital must make a written request for the waiver and the informal conference within the first thirty (30) days following notification of the assessment. The proceedings before the Commissioner involving penalty waivers are not subject to the Uniform Administrative Procedures Act.
- (11) After the conference with the Commissioner or the time frame for requesting a conference has expired, the Commissioner can collect the penalties unless the hospital appeals the Commissioner's decision. Penalties may be off set by funds owed to the hospital by the Department of Health and/or the Department of Finance and Administration. However, if the hospital wishes to appeal the decision of the Commissioner, a request in writing for a hearing before an Administrative Law Judge must be sent to the Commissioner within ten (10) business days of the Commissioner's written determination. Issues involving collection of penalties directly from hospitals resolved by an Administrative Law Judge will be in accordance with the Uniform

Administrative Procedures Act.

- (12) At the date of collection, penalties for the hospitals that have not submitted any discharge data will be collected based on the estimated number of discharges per day delinquent from the submission deadline to the collection date. Penalties for hospitals that have submitted data will be collected based on the actual number of discharge records that are incomplete or inaccurate for the particular quarter and the actual days delinquent.

**Authority:** *T.C.A. §§4-5-202, 4-5-204 and 68-1-108.*

Rule 1200-7-3-.05 Processing and Verification, is amended by deleting paragraphs (1), (4) and (5) and substituting instead the following new paragraphs (1) and (4):

- (1) If errors, inconsistencies, or incomplete elements are identified by the Department the errors will be reported to the hospital in writing. Upon receiving written notification of errors, the hospital facility shall investigate the problem and shall supply correct information within fifteen (15) days from notification.
- (4) Pursuant to (1) through (3) above, and all appropriate revisions have been made to the data by the Department, the data is considered verified.

**Authority:** *T.C.A. §§4-5-202, 4-5-204 and 68-1-108.*

1200-7-3-.06 Data Availability, is amended by deleting paragraphs (1) through (8) and substituting instead the following new paragraphs (1) through (5):

- (1) Within thirty (30) days after all hospitals' claims data has been accumulated into the Department's master database, and has been processed and verified, the Department will send THA a copy of the entire database.
- (2) The Commissioner has the authority to delay release of any particular data element(s) if it is determined that the quality or completeness of the information is not acceptable.
- (3) The Department may create reports for public release using any available processed and verified aggregate data. It may also provide custom reports, as requested by the public, using any available processed and verified aggregate data. Facility specific aggregate data reports will not be released to the public until at least four (4) consecutive quarters of data have been processed and verified.
- (4) A contractual agent of the Department or of the THA may receive reports of any record necessary, together with any needed patient identifiers, to carry out their contractual duties. This includes any organization contracted with to provide editing, quality control, database management services, or research for the Department or the THA. Any such contractual agent must agree in writing to establish and maintain appropriate controls to protect the confidentiality of the data and must agree to return or destroy any data or records at the termination of the contract.
- (5) Record level data files will be made available for public release and purchase under the following conditions. The fee for a quarter of inpatient data will be \$300. The fee for a quarter of outpatient data will be \$300. The fee for a subset of a quarter of data, inpatient or outpatient, will be \$300. The Department maintains a proprietary interest in all record level data files it sells or distributes and such files are made available solely for use by the purchaser and may not be given or sold to another entity. No record level data files will be made available for public release and purchase until eighteen months following the close of the data year.

**Authority:** *T.C.A. §§4-5-202, 4-5-204 and 68-1-108.*

Rule 1200-7-3-.07 Confidential Information, is amended by deleting paragraphs (4) and (5) and substituting instead the following new paragraphs (4) through (6):

- (4) To protect patient confidentiality both data files and reports released to the public must meet the following criteria:
  - (a) Patient Address City must be deleted.
  - (b) The month and day of all dates must be deleted.
  - (c) All zip code areas having a population under 20,000 must have no more than the first three digits shown. Zip code areas having a population of 20,000 or more must have no more than the first five digits shown.
  - (d) For patients over 89 years of age the Year of Birth must be deleted and the actual patient age may not be shown.
  - (e) Information that reasonably could be expected to reveal the identity of a patient including those items contained in 45 C.F.R. § 514 (a) and (b) shall be deleted.
- (5) Any agency of the State of Tennessee receiving confidential hospital claims data or reports containing such confidential information, shall agree in writing to follow all confidentiality restrictions of the Department concerning use of this data.
- (6) The Commissioner may use or authorize use of this data, including the patient identifiers, for purposes that are necessary to provide for or protect the health of the population and as permitted by law.

**Authority:** *T.C.A. §§4-5-202, 4-5-204 and 68-1-108.*

#### REPEALS

Rule 1200-7-3-108 is repealed.

**Authority:** *T.C.A. §§4-5-202, 4-5-204 and 68-1-108.*

The notice of rulemaking set out herein was properly filed in the Department of State on the 7th day of March, 2005.  
(03-14)