

**RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
HEALTH STATISTICS**

**CHAPTER 1200-7-3
HOSPITAL DISCHARGE DATA SYSTEM**

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1200-7-3-.01 DEFINITIONS.

- (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.

(Rule 1200-7-3-.01, continued)

- (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. **Administrative History:** Original rule filed July 30, 1987; effective September 13, 1987. Amendment filed May 7, 1997; effective July 21, 1997. Repeal and new rule filed May 7, 1997; effective July 21, 1997. Repeal and new rule filed June 14, 2006; effective August 28, 2006.

1200-7-3-.02 REQUIRED DATA ELEMENTS.

- (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.
- (2) The minimum data set for each reported discharge will include the following data elements:
 - (a) Patient Control Number
 - (b) Type of Bill
 - (c) Federal Tax Number
 - (d) Statement Covers Period
 - (e) Patient's Address: City, State and Zip Code
 - (f) Patient's Date of Birth
 - (g) Patient's Sex
 - (h) Admission Date
 - (i) Admission Type
 - (j) Source of Admission
 - (k) Patient's Status
 - (l) Medical/Health Record Number
 - (m) Revenue Codes
 - (n) Date(s) of Service
 - (o) Unit(s) of Service

(Rule 1200-7-3-.02, continued)

- (p) Charges Associated with Revenue Codes
 - (q) Payer Identification
 - (r) Provider Number
 - (s) Patient's Relationship to Insured
 - (t) Certificate Number/ID Number/SSN
 - (u) Insurance Group Number
 - (v) Employment Status Code
 - (w) Insured's Employer Name
 - (x) Insured's Employer Location: Zip Code
 - (y) Principal Diagnosis Codes
 - (z) Other Diagnosis Codes
 - (aa) E Code
 - (bb) Principal Procedure Code and Date
 - (cc) Other Procedure Codes and Dates
 - (dd) Attending Physician ID Number
 - (ee) Other Physician ID Numbers
 - (ff) Patient's Social Security Number
 - (gg) Patient's Race/Ethnicity
- (3) All inpatient discharges are required to be reported.
 - (4) All outpatient and emergency room discharges are required to be reported.
 - (5) All data elements reported by the hospital should be the actual values used by the hospital. None should be encrypted or otherwise altered.
 - (6) 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.
 - (7) All hospitals which are required to report data by T.C.A. §68-1-108 shall notify Health Statistics and Information on a form supplied by HSI of the name, title, work address, and work telephone number of the designated staff member.

(Rule 1200-7-3-.02, continued)

Authority: T.C.A. §§4-5-202, 4-5-204, and 68-1-108. **Administrative History:** Original rule filed July 30, 1987; effective September 13, 1987. Amendment filed May 7, 1997; effective July 21, 1997. Amendment filed June 14, 2006; effective August 28, 2006.

1200-7-3-.03 SUBMISSION TIME LINE.

- (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. **Administrative History:** Original rule filed July 30, 1987; effective September 13, 1987. Repeal and new rule filed May 7, 1997; effective July 21, 1997. Repeal and new rule filed June 14, 2006; effective August 28, 2006.

1200-7-3-.04 PENALTY ASSESSMENT.

- (1) The Department of Health will assess a civil penalty of five cents (\$.05) per record per day for delinquent discharge reports.
- (2) The maximum civil penalty for a delinquent report is ten dollars (\$10) for each discharge record.
- (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).

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.

(Rule 1200-7-3-.04, continued)

- (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. **Administrative History:** Original rule filed July 30, 1987; effective September 13, 1987. Repeal and new rule filed May 7, 1997; effective July 21, 1997. Amendment filed June 14, 2006; effective August 28, 2006.

1200-7-3-.05 PROCESSING AND VERIFICATION.

- (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.

(Rule 1200-7-3-.05, continued)

- (2) Discharge data reported in an incorrect format or with elements inconsistent with T.C.A. 68-1-108 will be considered in error and returned to the reporting entity.
- (3) Discharge data considered in error is subject to the penalties as prescribed in T.C.A. 68-1-108, unless the errors are corrected within fifteen (15) days after the hospital receives notification of existing errors.
- (4) After the quarterly data have been computerized, edited, updated, and determined to be the final corrected set by the Department, each hospital shall be given a ten (10) day opportunity to review the quarterly data set relating to their hospital, if they so desire. Upon the expiration of that ten day period, absent receipt of corrections and/or revisions from the hospitals, the quarterly data is considered verified. If corrections and/or revisions are received, the quarterly data is considered verified once the corrections and/or revisions have been made by the Department.
- (5) The same procedure as stated in paragraph (4) above shall be used for verification of the final data set at the close of the data year.

Authority: T.C.A. §§4-5-202, 4-5-204, and 68-1-108. **Administrative History:** Original rule filed July 30, 1987; effective September 13, 1987. Repeal and new rule filed May 7, 1997; effective July 21, 1997. Amendment filed June 14, 2006; effective August 28, 2006.

1200-7-3-.06 DATA AVAILABILITY.

- (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 the final data set for the calendar year has 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. **Administrative History:** Original rule filed July 30, 1987; effective September 13, 1987. Repeal and new rule filed May 7, 1997; effective July 21, 1997. Repeal and new rule filed June 14, 2006; effective August 28, 2006.

1200-7-3-.07 CONFIDENTIAL INFORMATION.

- (1) All information reported to the Commissioner under this part is confidential until processed and verified by the Commissioner.
- (2) In no event may patient identifiers be released to the public at any time.
- (3) Information regarding the name of an employer will not be released to the public. Information about any employer may be released to the employer identified in the data record. Hospitals may receive information regarding the name of employer for their claims only.
- (4) The data may be released pursuant to 45 C.F.R. § 164.514 (b) or (e). However if either data files and/or reports are otherwise released to the public, to protect patient confidentiality, they 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. §164(b)(2)(i) 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. **Administrative History:** Original rule filed July 30, 1987; effective September 13, 1987. Repeal and new rule filed May 7, 1997; effective July 21, 1997. Amendment filed June 14, 2006; effective August 28, 2006.

1200-7-3-.08 REPEALED.

Authority: T.C.A. §§4-5-202, 4-5-204, and 68-1-108. **Administrative History:** Original rule filed May 7, 1997; effective July 21, 1997. Repeal filed June 14, 2006; effective August 28, 2006.