

**RULES
OF
THE TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
BUREAU OF WORKERS' COMPENSATION**

**CHAPTER 0800-02-26
ELECTRONIC MEDICAL BILLING FOR WORKERS' COMPENSATION**

TABLE OF CONTENTS

0800-02-26-.01	Scope	0800-02-26-.07	Communication Between Health Care Providers and Payers
0800-02-26-.02	Definitions	0800-02-26-.08	Medical Documentation Necessary for Billing Adjudication
0800-02-26-.03	Formats for Electronic Medical Bill Processing	0800-02-26-.09	Compliance and Penalty
0800-02-26-.04	Billing Code Sets	0800-02-26-.10	Effective Date
0800-02-26-.05	Electronic Medical Billing, Reimbursement, and Documentation		
0800-02-26-.06	Employer, Insurance Carrier, Managed Care Organization, or Agents' Receipt of Medical Bills from Health Care Providers		

0800-02-26-.01 SCOPE.

- (1) The purpose of this rule is to provide a legal framework for electronic billing, processing, and payment of medical services and products provided to an injured employee and data reporting subject to Tennessee Code Annotated § 50-6-202.

Authority: T.C.A. § 50-6-202(a)-(c). **Administrative History:** Original rules filed December 13, 2017; effective March 13, 2018.

0800-02-26-.02 DEFINITIONS.

- (1) "Business day" means Monday through Friday, excluding days on which a holiday is observed by this jurisdiction.
- (2) "CAQH CORE" Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange is a national standards organization that develops operating rules for the business aspects of the United States Department of Health and Human Services (HHS) mandates for electronic healthcare transactions.
- (3) "Clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that is an agent of either the payer or the provider and that may perform the following functions:
 - (a) Processes or facilitates the processing of medical billing information received from a client in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction for further processing of a bill related transaction; or
 - (b) Receives a standard transaction from another entity and processes or facilitates the processing of medical billing information into nonstandard format or nonstandard data content for a client entity.
- (4) "CMS" means the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services (HHS), the federal agency that administers these programs.

(Rule 0800-02-26-.02, continued)

- (5) "Companion Guide" means the Tennessee Bureau of Workers' Compensation Electronic Billing and Payment Companion Guide, based on IAIABC National Companion Guide, and is a separate document which gives detailed information for Electronic Data Interchange (EDI) medical billing and payment for the workers' compensation industry using national standards and Tennessee jurisdictional procedures.
- (6) "Complete electronic medical bill" means a medical bill that meets all of the criteria enumerated in 0800-02-26-.05(3).
- (7) "Electronic" refers to communication between computerized data exchange systems that complies with the standards enumerated in this rule.
- (8) "Health care provider" means a person or entity, appropriately certified or licensed, as required, who provides medical services or products to an injured worker in accordance with 0800-02-06. Health Care Providers are responsible for the acts or omissions of their agents related to the performance of electronic medical billing services.
- (9) "Health care provider agent" means a person or entity that contracts with a health care provider establishing an agency relationship to process bills for services provided by the health care provider under the terms and conditions of a contract between the agent and health care provider. Such contracts may permit the agent to submit bills, request reconsideration, receive reimbursement, and seek medical dispute resolution for the health care provider services billed in accordance with Tennessee Workers' Compensation Act and bureau rules.
- (10) "Health Plan Identifier" or "HPID" means an identifier for health plans (as defined in 45 CFR § 160.103) that need to be identified in standard transactions.
- (11) "National Provider Identification Number" or "NPI" means the unique identifier assigned to a health care provider or health care facility by the Secretary of the United States Department of Health and Human Services.
- (12) "Other Entity Identifier" or "OEID" means an identifier for entities that are not health plans, health care providers, or "individuals" (as defined in 45 CFR § 160.103), but that need to be identified in standard transactions (including, for example, workers' compensation payers, third party administrators, transaction vendors, clearinghouses, and other payers).
- (13) "Operating Rules" means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.
- (14) "Payer" means the employer, its insurer or authorized self-insured employer or an entity authorized to make payments on behalf of the insurer or authorized self-insured employer legally responsible for paying the workers' compensation medical bills. Payers are responsible for the acts or omissions of their agents related to the performance of electronic medical billing services.
- (15) "Payer agent" here is broadly construed to mean any person or entity that performs medical bill related processes for the payer responsible for the bill. These processes include, but are not limited to, reporting to government agencies, electronic transmission, forwarding, or receipt of documents, review of reports, adjudication of bills, and their final payment.

(Rule 0800-02-26-.02, continued)

- (16) "Supporting documentation" means those documents necessary for the payer to process a bill. These include, but are not limited to, any written authorization received from the third party administrator or any other records as required by 0800-02-26-.05.
- (17) "Technical Report Type 3" (TR3 Implementation Guide) is an ASC X12 published document for national electronic standard formats that specifies data requirements and data transaction sets, as referenced in 0800-02-26-.03 of this rule.

Authority: T.C.A. § 50-6-202(a)-(c). **Administrative History:** Original rules filed December 13, 2017; effective March 13, 2018.

0800-02-26-.03 FORMATS FOR ELECTRONIC MEDICAL BILL PROCESSING.

- (1) For electronic transactions, the most current version of the following electronic medical bill processing standards shall be used:
 - (a) Billing:
 1. Professional Billing – the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Professional (837), May 2006, ASC X12, 005010X222 and Type 3 Errata to Health Care Claim: Professional (837), June 2010, ASC X12, 005010X222A1.
 2. Institutional/Hospital Billing – the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Institutional (837), May 2006, ASC X12N/005010X223, Type 1 Errata to Health Care Claim: Institutional (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12N/005010X223A1, and Type 3 Errata to Health Care Claim: Institutional (837), June 2010, ASC X12, 005010X223A2.
 3. Dental Billing – the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Dental (837), May 2006, ASC X12N/005010X224, Type 1 Errata to Health Care Claim: Dental (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12N/005010X224A1, and Type 3 Errata to Health Care Claim: Dental (837), June 2010, ASC X12, 005010X224A2.
 4. Retail Pharmacy Billing – the Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, National Council for Prescription Drug Programs and the Batch Standard Batch Implementation Guide, Version 1, Release 2 (Version 1.2), January 2006, National Council for Prescription Drug Programs.
 - (b) Acknowledgment:
 1. Electronic responses to ASC X12N 837 transactions:
 - (i) The ASC X12 Standards for Electronic Data Interchange TA1 Interchange Acknowledgment contained in the standards adopted under subsection (a)1. of this section;
 - (ii) The ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Implementation Acknowledgment for Health Care Insurance (999), June 2007, ASC X12N/005010X231; and

(Rule 0800-02-26-.03, continued)

- (iii) The ASC X12 Standards for Electronic Data Interchange Technical Report Type (iii) Health Care Claim Acknowledgment (277CA), January 2007, ASC X12N/005010X214.
 2. Electronic responses to NCPDP transactions:
 - (i) The Response contained in the standards adopted under subsection (1)(a) of this section.
 - (c) Electronic Remittance Advice (ERA) – the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim Payment/Advice (835), April 2006, ASC X12N/005010X221 and Type 3 Errata to Health Care Claim Payment/Advice (835), June 2010, ASC X12, 005010X221A1.
 - (d) ASC X12 Ancillary Formats
 1. The ASC X12N/005010X213 Request for Additional Information (277) is used to request additional attachments that were not originally submitted with the electronic medical bill.
 2. Health Claim Status Request and Response
 - (e) Documentation submitted with an electronic medical bill in accordance with 0800-02-26-.05(5) (relating to Medical Documentation): ASC X12N Additional Information to Support a Health Claim or Encounter (275), February 2008, ASC X12, 005010X210.
- (2) Insurance carriers and health care providers may exchange electronic data in a non-prescribed format by mutual agreement. All data elements required in the Tennessee-prescribed formats shall be present in any mutually agreed upon format.
- (3) The implementation specifications for the ASC X12N and the ASC X12 Standards for Electronic Data Interchange may be obtained from the ASC X12, 7600 Leesburg Pike, Suite 430, Falls Church, VA 22043; Telephone (703) 970-4480; and FAX (703) 970-4488. They are also available through the Internet at <http://store.x12.org/>. A fee is charged for all implementation specifications.
- (4) The implementation specifications for the retail pharmacy standards may be obtained from the National Council for Prescription Drug Programs, 9240 East Raintree Drive, Scottsdale, AZ 85260; Telephone (480) 477-1000; and FAX (480) 767-1042. They are also available through the Internet at <http://www.ncdp.org>. A fee is charged for all implementation specifications.
- (5) Nothing in this section will prohibit payers and health care providers from using a direct data entry methodology for complying with these requirements, provided the methodology complies with the data content requirements of the adopted formats and these rules.
- (6) Whenever the formats enumerated in section (1) for billing, acknowledgment, remittance, and documentation are replaced with a newer version, the most recent standard shall be used. The requirement to use a new version will commence on the effective date of the new version as published in the Code of Federal Regulations.

Authority: T.C.A. § 50-6-202. **Administrative History:** Original rules filed December 13, 2017; effective March 13, 2018. Amendments filed June 24, 2021; effective September 22, 2021.

0800-02-26-.04 BILLING CODE SETS.

Billing codes and modifier systems identified below are valid codes for the specified workers' compensation transactions, in addition to any code sets defined by the standards adopted in 0800-02-26-.04.

- (1) "CDT-4 Codes" – codes and nomenclature prescribed by the American Dental Association.
- (2) "CPT® Codes" – the procedural terminology and codes contained in the "Current Procedural Terminology," as published by the American Medical Association and as adopted in the appropriate fee schedule effective on the date of service. See 0800-02-17.
- (3) "Diagnosis Related Group (MS-DRG)" – the inpatient classification scheme used by CMS for hospital inpatient reimbursement. The MS-DRG system classifies patients based on principal diagnosis, surgical procedure, age, presence of co-morbidities and complications, and other pertinent data that demonstrate similar resource consumption and length of stay patterns as defined by Medicare.
- (4) "HCPCS" – CMS' Healthcare Common Procedure Coding System, a coding system which describes products, supplies, procedures, and health professional services and which includes the American Medical Association's (AMA's) Physician "Current Procedural Terminology, CPT®, codes, alphanumeric codes, and related modifiers.
- (5) "ICD-9-CM Codes" – diagnosis and procedure codes in the International Classification of Diseases, Ninth Revision, Clinical Modification published by the United States Department of Health and Human Services are adopted by reference.
- (6) "ICD-10-CM/PCS Codes" – diagnosis and procedure codes in the International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System maintained and published by the United States Department of Health and Human Services are adopted by reference.
- (7) "NDC" – National Drug Codes of the United States Food and Drug Administration.
- (8) "Revenue Codes" – the 4-digit coding system developed and maintained by the National Uniform Billing Committee for billing inpatient and outpatient hospital services, home health services, and hospice services.
- (9) "National Uniform Billing Committee Codes" – code structure and instructions established for use by the National Uniform Billing Committee (NUBC), such as occurrence codes, condition codes, or prospective payment indicator codes. As of the date of publication of this model rule, these are known as UB04 codes.
- (10) "Narrative Medical Reports" required by 0800-02-17-.15 shall use the procedure codes WC101, WC102 and WC103 as specified therein. (eBill Companion Guide – Chapter 2.8)

Authority: T.C.A. § 50-6-202(a)-(c). **Administrative History:** Original rules filed December 13, 2017; effective March 13, 2018.

0800-02-26-.05 ELECTRONIC MEDICAL BILLING, REIMBURSEMENT, AND DOCUMENTATION.

- (1) Applicability
 - (a) This section outlines the exclusive process for the initial exchange of electronic medical bill and related payment processing data for professional, institutional/hospital, pharmacy, and dental services.

(Rule 0800-02-26-.05, continued)

- (b) Unless exempted from this process in accordance with subsection (2) of this section, payers or their agents shall:
 - 1. Accept electronic medical bills submitted in accordance with the adopted standards;
 - 2. Transmit acknowledgments and remittance advice in compliance with the adopted standards in response to electronically submitted medical bills; and
 - 3. Support methods to receive electronic documentation required for the adjudication of a bill, as described in 0800-02-26-.08 below.
 - (c) A health care provider shall:
 - 1. Implement a software system capable of exchanging medical bill data in accordance with the adopted standards, or contract with a clearinghouse to exchange its medical bill data;
 - 2. Submit medical bills as defined by 0800-02-26-.03(1)(a) to any payers that have established connectivity to the health care provider's system or clearinghouse;
 - 3. Submit required documentation in accordance with subsection (5) below; and
 - 4. Receive and process any acceptance or rejection acknowledgment from the payer.
 - (d) Payers shall be able to exchange electronic data by January 1, 2018, unless exempted from the process in accordance with subsection (2) of this section.
 - (e) Health care providers or their agents shall be able to exchange electronic data by June 1, 2018, unless exempted from the process in accordance with subsection (2) of this section.
- (2) Exceptions to Mandatory Participation
- (a) A health care provider is waived from the requirement to submit medical bills electronically to a payer if:
 - 1. The health care provider employs 10 or fewer full-time employees (used by Medicare), or
 - 2. The health care provider submitted fewer than one hundred twenty (120) bills for workers' compensation treatment in the previous calendar year.
 - 3. The Bureau of Workers' Compensation may grant an exception on a case-by-case basis if the health care provider establishes that electronic billing will result in an unreasonable financial burden.
 - (b) A payer is waived from the requirement to receive medical bills electronically from health care providers if:
 - 1. The payer processed fewer than two hundred fifty (250) medical bills for workers' compensation treatment or services in the previous calendar year.

(Rule 0800-02-26-.05, continued)

2. The Bureau of Workers' Compensation may grant an exception on a case-by-case basis if the payer establishes that electronic billing will result in an unreasonable financial burden.
- (3) Complete Electronic Medical Bill. To be considered a complete electronic medical bill, the bill or supporting transmissions shall:
- (a) Be submitted in the correct billing format;
 - (b) Be transmitted in compliance with the format requirements described in 0800-02-26-.03 of this rule;
 - (c) Include in legible text all supporting documentation for the bill, including, but not limited to, medical reports and records, evaluation reports, narrative reports, assessment reports, progress reports/notes, clinical notes, hospital records and diagnostic test results that are expressly required by Rule 0800-02-17-.03;
 - (d) Identify the:
 1. Injured employee;
 2. Employer;
 3. Insurance carrier, third party administrator, managed care organization or its agent; Health care provider;
 4. Medical service product; and
 5. Any other requirements as presented in the Tennessee electronic billing companion guide; and
 - (e) Use current and valid codes and values as defined in the applicable formats referenced in the jurisdictional regulatory requirements.
- (4) Acknowledgement
- (a) An Interchange Acknowledgment (TA1) notifies the sender of the receipt of, and certain structural defects associated with, an incoming transaction.
 - (b) An Implementation Acknowledgment (ASC X12 999) transaction is an electronic notification to the sender of the file that it has been received and has been:
 1. Accepted as a complete and structurally correct file, or
 2. Rejected with a valid rejection error code.
 - (c) A Health Care Claim Acknowledgment (ASC X12 277CA) is an electronic acknowledgment to the sender of an electronic transaction that the transaction has been received and has been:
 1. Accepted as a complete, correct submission, or
 2. Rejected with a valid rejection error code.

(Rule 0800-02-26-.05, continued)

- (d) A payer shall acknowledge receipt of an electronic medical bill by returning an Implementation Acknowledgment (ASC X12 999) within one (1) business day of receipt of the electronic submission.
 - 1. Notification of a rejected bill is transmitted using the appropriate acknowledgment when an electronic medical bill does not meet the definition of a complete electronic medical bill as described in 0800-02-26-.05(5) or does not meet the edits defined in the applicable implementation guide or guides.
 - 2. A health care provider or its agent shall not submit a duplicate electronic medical bill earlier than 60 calendar days from the date originally submitted if a payer has acknowledged acceptance of the original complete electronic medical bill. A health care provider or its agent may submit a corrected medical bill electronically to the payer after receiving notification of a rejection. The corrected medical bill is submitted as a new, timely original bill if resubmitted within 60 days of the notice of rejection.
- (e) A payer shall acknowledge receipt of an electronic medical bill by returning a Health Care Claim Acknowledgment (ASC X12 277CA) transaction (detail acknowledgment) within two (2) business days of receipt of the electronic submission.
 - 1. Notification of a rejected bill is transmitted in an ASC X12N 277CA response or acknowledgment when an electronic medical bill does not meet the definition of a complete electronic medical bill or does not meet the edits defined in the applicable implementation guide or guides.
 - 2. A health care provider or its agent shall not submit a duplicate electronic medical bill earlier than 60 calendar days from the date originally submitted if a payer has acknowledged acceptance of the original complete electronic medical bill. A health care provider or its agent may submit a corrected medical bill electronically to the payer after receiving notification of a rejection. The corrected medical bill is submitted as a new, timely original bill if resubmitted within 60 days of the notice of rejection.
- (f) Acceptance of a complete medical bill is not an admission of liability by the payer. A payer may subsequently reject an accepted electronic medical bill if the employer or other responsible party named on the medical bill is not legally liable for its payment.
 - 1. The rejection is transmitted by means of an 835 transaction.
 - 2. The subsequent rejection of a previously accepted electronic medical bill shall occur no later than fifteen (15) business days from the date of receipt of the complete electronic medical bill.
 - 3. The transaction to reject the previously accepted complete medical bill shall clearly indicate that the reason for rejection is that the payer is not legally liable for its payment.
- (g) Acceptance of an incomplete medical bill does not satisfy the written notice of injury requirement from an employee or payer as required in T.C.A. § 50-6-201.
- (h) Acceptance of a complete or incomplete medical bill by a payer does not begin the time period by which a payer shall accept or deny liability for any alleged claim related to such medical treatment.

(Rule 0800-02-26-.05, continued)

- (i) Transmission of an Implementation Acknowledgment under 0800-02-26-.05(4)(b), and acceptance of a complete, structurally correct file serves as proof of the received date for an electronic medical bill in 0800-02-26-.05(3).
- (5) Electronic Documentation
- (a) Electronic documentation, including but not limited to medical reports and records submitted electronically that support an electronic medical bill, may be required by the payer before payment may be remitted to the health care provider, in accordance with regulations established by the Bureau of Workers' Compensation here and in 0800-02-17. Further information is available in the Tennessee Bureau of Workers' Compensation Electronic Billing and Payment Companion Guide, a copy of which is available on the Bureau website and is adopted herein by reference.
 - (b) Complete electronic documentation shall be submitted by secure fax, secure encrypted electronic mail, or in a secure electronic format as defined in 0800-02-26-.03.
 - (c) The electronic transmittal, either by secure fax or by secure encrypted electronic mail or any other secure electronic format, shall prominently contain the following details on its cover sheet or first page of the transmittal:
 1. The name of the injured employee,
 2. Identification of the worker's employer, the employer's insurance carrier, or the third party administrator or its agent handling the workers' compensation claim;
 3. Identification of the health care provider billing for services to the injured worker, and where applicable, its agent;
 4. Date(s) of service;
 5. The workers' compensation claim number assigned by the payer, if established by the payer; and
 6. The unique attachment indicator number.
 - (d) When requested by the payer, a health care provider or its agent shall submit electronic documentation within seven (7) business days of the payer's request.
 1. Electronic documentation may be submitted simultaneously with the electronic medical bill.
 2. Electronic documentation may be submitted separately from the electronic medical bill within seven (7) business days of successful submission of the electronic medical bill.
- (6) Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)
- (a) An Electronic Remittance Advice (ERA) is an Explanation of Benefits (EOB) or Explanation of Review (EOR), submitted electronically, regarding payment or denial of a medical bill, recoupment request, or receipt of a refund.
 - (b) All payments for service are required to be paid via electronic funds transfer (EFT) unless an alternate electronic method is agreed upon by the payer and provider. The operating rules must comply with the Committee on Operating Rules for Information

(Rule 0800-02-26-.05, continued)

Exchange of the Council for Affordable Quality Health Care to comply with applicable Federal standards.

- (c) The ERA shall contain the appropriate Group Claim Adjustment Reason Codes, Claim Adjustment Reason Codes (CARC) and associated Remittance Advice Remark Codes (RARC) as specified in the Code Value Usage in Health Care Claim Payments and Subsequent Claims Technical Report Type 2 (TR2) Workers' Compensation Code Usage Section and for pharmacy charges, the National Council for Prescription Drugs Program (NCPDP) Reject Codes, denoting the reason for payment, adjustment, or denial.
- (d) The ERA shall be sent within five (5) business days of:
 - 1. The expected date of receipt by the medical provider of payment from the payer, or
 - 2. The date of the bill's rejection by the payer.
- (7) Requirements for Health Care Providers Exempted from Electronic Billing
 - (a) Health care providers exempted from electronic medical billing pursuant to 0800-02-26-.05(2) shall submit paper medical bills for payment in the following formats as applicable:
 - 1. On the current standard forms used by the Centers for Medicare and Medicaid Services (CMS);
 - 2. On the current National Council for Prescription Drug Programs (NCPDP) Workers' Compensation/Property and Casualty Universal Claim Form (WC/PC UCF);
 - 3. On the current American Dental Association (ADA) Claim Form.
- (8) Resubmissions
 - (a) A health care provider or its agent shall not submit a duplicate medical bill earlier than 30 calendar days from the date originally submitted unless the payer has rejected the medical bill as incomplete in accordance with 0800-02-26-.06 (Employer, Insurance Carrier, Managed Care Organization, or Agents' Receipt of Medical Bills from Health Care Providers). A health care provider or its agent may submit a corrected medical bill to the payer after receiving notification of the rejection of an incomplete medical bill. The corrected medical bill is submitted as a new, timely original bill if resubmitted within 60 calendar days of the notice of rejection.
- (9) Connectivity
 - (a) Unless the payer or its agent is exempted from the electronic medical billing process in accordance with 0800-02-26-.05 (Electronic Medical Billing, Reimbursement, and Documentation), it should attempt to establish connectivity through a trading partner agreement with any clearinghouse that requests the exchange of data in accordance with 0800-02-26-.03 (Formats for Electronic Medical Bill Processing).
- (10) Fees

(Rule 0800-02-26-.05, continued)

- (a) No party to the electronic transactions shall charge excessive fees of any other party in the transaction. A payer or clearinghouse that requests another payer or clearinghouse to receive, process, or transmit a standard transaction shall not charge fees or costs in excess of the fees or costs for normal telecommunications that the requesting entity incurs when it directly transmits, or receives, a standard transaction.
- (11) A health care provider agent may charge reasonable fees related to data translation, data mapping, and similar data functions when the health care provider is not capable of submitting a standard transaction. In addition, a health care provider agent may charge a reasonable fee related to:
 - (a) Transaction management of standard transactions, such as editing, validation, transaction tracking, management reports, portal services and connectivity; and,
 - (b) Other value added services, such as electronic file transfers related to medical documentation.
- (12) A payer or its agent shall not reject a standard electronic transaction on the basis that it contains data elements not needed or used by the payer or its agent or that the electronic transaction includes data elements that exceed those required for a complete bill as enumerated in 0800-02-26-.05(3).
- (13) A health care provider that has not implemented a software system capable of sending standard transactions is required to use a secure Internet-based direct data entry system offered by a payer if the payer does not charge a transaction fee. A health care provider using an Internet-based direct data entry system offered by a payer or other entity shall use the appropriate data content and data condition requirements of the standard transactions.
- (14) The payer's failure to comply with any requirements of this rule will result in an administrative violation under 0800-02-17-.13, 0800-02-18-.15, 0800-02-19-.06, 0800-02-01-.10 or T.C.A. § 50-6-125 as applicable.

Authority: T.C.A. § 50-6-202. **Administrative History:** Original rules filed December 13, 2017; effective March 13, 2018. Amendments filed June 24, 2021; effective September 22, 2021.

0800-02-26-.06 EMPLOYER, INSURANCE CARRIER, MANAGED CARE ORGANIZATION, OR AGENTS' RECEIPT OF MEDICAL BILLS FROM HEALTH CARE PROVIDERS.

- (1) Upon receipt of medical bills submitted in accordance with 0800-02-26-.03, 0800-02-26-.04, and 0800-02-26-.05, a payer shall evaluate each bill's conformance with the criteria of a complete electronic medical bill.
 - (a) A payer shall not reject medical bills that are complete, unless the bill is a duplicate bill.
 - (b) Upon receipt of an incomplete medical bill, a payer or its agent shall either:
 - 1. Complete the bill by adding missing health care provider identification or demographic information already known to the payer within 15 business days; or,
 - 2. Reject the incomplete bill, in accordance with subsection .06(6).
- (2) The received date of an electronic medical bill is the date all of the contents of a complete electronic bill are successfully received by the claims payer.

(Rule 0800-02-26-.06, continued)

- (3) The payer may contact the medical provider to obtain the information necessary to make the bill complete.
 - (a) Any request by the payer or its agent for additional documentation to pay a medical bill shall:
 1. Be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery;
 2. Be specific to the bill or the bill's related episode of care;
 3. Describe with specificity the clinical and other information to be included in the response;
 4. Be relevant and necessary for the resolution of the bill;
 5. Be for information that is contained in or is in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider; and
 6. Indicate the specific reason for which the insurance carrier is requesting the information.
 - (b) If the payer or its agent obtains the missing information and completes the bill to the point that it can be adjudicated for payment, the payer shall document the name and telephone number of the person who supplied the information.
 - (c) Health care providers and payers, or their agents, shall maintain documentation of any pertinent internal or external communications that are necessary to make the medical bill complete.
- (4) A payer shall not reject or deny a medical bill except as provided in subsection (1) of this section. When rejecting or denying an electronic medical bill, the payer shall clearly identify the reason(s) for the bill's rejection or denial by utilizing the appropriate codes in the standard transactions pursuant to 0800-02-26-.05(4)(c)2.
- (5) The rejection of an incomplete medical bill in accordance with this section fulfills the obligation of the payer to provide to the health care provider or its agent information related to the incompleteness of the bill.
- (6) Payers shall timely reject incomplete bills or request additional information needed to reasonably determine the amount payable.
 - (a) For bills submitted electronically, the rejection of the entire bill or the rejection of specific service lines included in the initial bill shall be sent to the submitter within two business days of receipt.
 - (b) If bills are submitted in a batch transmission, only the specific bills failing edits shall be rejected.
 - (c) If there is a technical defect within the transmission itself that prevents the bills from being accessed or processed, the transmission will be rejected with a TA1 and/or a 999 transaction, as appropriate.

(Rule 0800-02-26-.06, continued)

- (7) If a payer has reason to challenge the coverage or amount of a specific line item on a bill, but has no reasonable basis for objections to the remainder of the bill, the uncontested portion shall be paid timely, as in subsection H below.
- (8) Payment of all uncontested portions of a complete medical bill shall be made to the provider within 30 calendar days of receipt of the original bill, or receipt of additional information requested by the payer allowed under the law.
- (9) A payer shall not reject or deny a medical bill except as provided in subsection (1). When rejecting or denying a medical bill, the payer shall also communicate to the provider the reason(s) for the medical bill's rejection or denial.
- (10) The payer's failure to comply with any requirements of this rule will result in an administrative violation in accordance with 0800-02-17, 0800-02-18, 0800-02-19, 0800-02-01, or T.C.A. § 50-6-125 as applicable.

Authority: T.C.A. § 50-6-202. **Administrative History:** Original rules filed December 13, 2017; effective March 13, 2018. Amendments filed June 24, 2021; effective September 22, 2021.

0800-02-26-.07 COMMUNICATION BETWEEN HEALTH CARE PROVIDERS AND PAYERS.

- (1) Any communication between the health care provider and the payer related to medical bill processing shall be of sufficient specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "payer improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position do not satisfy the requirements of this Section.
- (2) The payer's utilization of the Claim Adjustment Group Codes, Claim Adjustment Reason Codes, and/or the Remittance Advice Remark Codes, or as appropriate, the NCPDP Reject/Payment Codes, when communicating with the health care provider or its agent or assignee, through the use of the 835 transaction, provides a standard mechanism to communicate issues associated with the medical bill.
- (3) Communication between the health care provider and payer related to medical bill processing shall be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery.
- (4) The payer's failure to comply with any requirements of this rule will result in an administrative violation in accordance with 0800-02-17, 0800-02-18, 0800-02-19, 0800-02-01, or T.C.A. § 50-6-125 as applicable.

Authority: T.C.A. § 50-6-202(a)-(c). **Administrative History:** Original rules filed December 13, 2017; effective March 13, 2018.

0800-02-26-.08 MEDICAL DOCUMENTATION NECESSARY FOR BILLING ADJUDICATION.

- (1) Medical documentation includes all medical reports and records permitted or required in accordance with T.C.A. § 50-6-204(a)(2)(A)-(D).
- (2) For the purposes of these Rules, requests for medical reports shall not require any releases by the patient pursuant to T.C.A. § 50-6-204(a)(2)(A)-(D).

(Rule 0800-02-26-.08, continued)

- (3) Any request by the payer for additional documentation to process a medical bill shall conform to the requirements of 0800-02-26-.06(3).
- (4) It is the obligation of an insurer or employer to furnish its agents with any documentation necessary for the resolution of a medical bill.
- (5) Health care providers, health care facilities, third-party biller/assignees, and claims administrators and their agents shall comply with all applicable Federal and jurisdictional rules related to privacy, confidentiality, and security.

Authority: T.C.A. § 50-6-202(a)-(c). **Administrative History:** Original rules filed December 13, 2017; effective March 13, 2018.

0800-02-26-.09 COMPLIANCE AND PENALTY.

- (1) Any electronically submitted bill determined to be complete but not paid within 30 calendar days or objected to within 30 calendar days will be subject to penalties of not less than \$50.00 nor more than \$5,000.00. Disputes on medical bill payments between providers and payers may be submitted to the Medical Payment Committee pursuant to T.C.A. § 50-6-125.
- (2) The Tennessee Bureau of Workers' Compensation may impose a civil monetary penalty if it determines that a payer has failed to comply with the electronic claims acceptance and response process by the effective date adopted in 0800-02-26-.10. The amount of a civil monetary penalty will be up to \$500.00 for each violation, but shall not exceed \$5,000.00 for identical violations during a calendar year.

Authority: T.C.A. § 50-6-202. **Administrative History:** Original rules filed December 13, 2017; effective March 13, 2018. Amendments filed June 24, 2021; effective September 22, 2021.

0800-02-26-.10 EFFECTIVE DATE.

- (1) These Rules are required for all medical services and products provided on or after July 1, 2018. For medical services and products provided prior to July 1, 2018, medical billing and processing shall be in accordance with the rules in effect at the time the health care was provided unless both payer and provider elect to comply with these Rules.

Authority: T.C.A. § 50-6-202(a)-(c). **Administrative History:** Original rules filed December 13, 2017; effective March 13, 2018.