

Chapter 82-75 WAC
ALL PAYER HEALTH CARE CLAIMS DATA BASE

NEW SECTION

WAC 82-75-010 Purpose. (1) Chapter 43.371 RCW establishes the framework for the creation and administration of a statewide all-payer health care claims data base.

(2) RCW 43.371.020 directs the office of financial management to establish a statewide all-payer health care claims data base to support transparent public reporting of health care information. The office shall select a lead organization to coordinate and manage the data base. The lead organization shall also contract with a data vendor to perform data collection, processing, aggregation, extracts, and analytics.

(3) RCW 43.371.070 mandates that the director of the office of financial management adopt rules necessary to implement chapter 43.371 RCW. In addition, RCW 43.371.010 and 43.371.050 direct the adoption of specific rules by the director.

(4) The purpose of this chapter is to implement chapter 43.371 RCW, to facilitate the creation and administration of the Washington statewide all-payer health care claims data base.

NEW SECTION

WAC 82-75-020 Definitions required by chapter 43.371 RCW. The following definitions apply throughout this chapter unless the context clearly indicates another meaning.

"Allowed amount" means the maximum dollar amount contractually agreed to for an eligible health care service covered under the terms of an insurance policy, health benefits plan or state labor and industries program.

"Billed amount" means the dollar amount charged for a health care service rendered.

"Claim file" means a data set composed of health care service level remittance information for all nondenied adjudicated claims under the terms of an insurance policy, health benefits plan or state labor and industries program including, but not limited to, covered medical services files, pharmacy files and dental files.

"Covered medical services file" means a data set composed of service level remittance information for all nondenied adjudicated claims for Washington covered persons that are authorized under the terms of an insurance policy, health benefits plan or state labor and industries program including, but not limited to, member demographics, provider information, charge and payment information including facility fees, clinical diagnosis codes and procedure codes.

"Data file" means a data set composed of member or provider information including, but not limited to, member eligibility and enrollment data and provider data with necessary identifiers.

"Dental claims file" means a data set composed of service level remittance information for all nondenied adjudicated claims for dental services for Washington covered persons including, but not limited to, member demographics, provider information, charge and payment information including facility fees, and current dental terminology codes as defined by the American Dental Association.

"Member eligibility and enrollment data file" means a data set containing data about Washington covered persons who receive health care coverage from a payer for one or more days of coverage during the reporting period including, but not limited to, subscriber and member identifiers, member demographics, plan type, benefit codes, and enrollment start and end dates.

"Paid amount" means the actual dollar amount paid for a health care service rendered under the terms of an insurance policy, health benefits plan or state labor and industries program for covered services, excluding member copayments, coinsurance, deductibles and other sources of payment.

"Pharmacy claims file" means a data set containing service level remittance information for all nondenied adjudicated claims for pharmacy services for Washington covered persons including, but not limited to, enrolled member demographics, provider information, charge and payment information including dispensing fees, and national drug codes.

"Provider data with necessary identifiers" means a data file containing information about health care providers that submitted claims for providing health care services, equipment or supplies, to subscribers or members and such other data as required by the data submission guide.

NEW SECTION

WAC 82-75-030 Additional definitions authorized by chapter 43.371 RCW. The following additional definitions apply throughout this chapter unless the context clearly indicates another meaning.

"Claim" means a request or demand on a carrier, third-party administrator, or the state labor and industries program for payment of a benefit.

"Coinsurance" means the percentage or amount an enrolled member pays towards the cost of a covered service.

"Copayment" means the fixed dollar amount a member pays to a health care provider at the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.

"Data submission guide" means the document that contains data submission requirements including, but not limited to, required fields, file layouts, file components, edit specifications, instructions and other technical specifications.

"Deductible" means the total dollar amount an enrolled member pays on an incurred claim toward the cost of specified covered services designated by the policy or plan over an established period of time before the carrier or third-party administrator makes any payments under an insurance policy or health benefit plan.

"Director" means the director of the office of financial management.

"Health benefits plan" or "health plan" has the same meaning as in RCW 48.43.005.

"Health care" means care, services, or supplies related to the prevention, cure or treatment of illness, injury or disease of an individual, which includes medical, pharmaceutical or dental care. Health care includes, but is not limited to:

(a) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and

(b) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

"Lead organization" means the entity selected by the office of financial management to coordinate and manage the data base as provided in chapter 43.371 RCW.

"Member" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

"Office" means the Washington state office of financial management.

"Subscriber" means the insured individual who pays the premium or whose employment makes him or her eligible for coverage under an insurance policy or member of a health benefit plan.

"WA-APCD" means the statewide all payer health care claims data base authorized in chapter 43.371 RCW.

"Washington covered person" means any eligible member and all covered dependents where the state of Washington has primary jurisdiction, and whose laws, rules and regulations govern the members' and dependents' insurance policy or health benefit plan.

NEW SECTION

WAC 82-75-040 Registration requirements. (1) **Initial registration.** Each data supplier required to submit health care data pursuant to chapter 43.371 RCW shall register within thirty days of notification from the lead organization.

(2) **Annual registration.** Each data supplier required to submit health care data pursuant to chapter 43.371 RCW shall register by December 31st of each year after the initial registration. If the data supplier initially registers September 1st or later, then the data supplier shall file its annual registration by December 31st of the year following the year of the initial registration.

(3) Each data supplier newly required to submit health care data under chapter 43.371 RCW, either by a change in law or loss of qualified exemption, shall register with the lead organization within thirty days of being required to submit data.

NEW SECTION

WAC 82-75-050 Data submission schedule. (1) Data suppliers shall submit the required health care data in accordance with the schedule provided in this section.

(2) **Test file.**

(a) At least sixty calendar days prior to the data suppliers' first required submission, the lead organization will notify the data supplier in writing regarding the obligation to file. The lead organization will schedule time to work with the data supplier to establish a schedule for when the data supplier shall submit the initial test files.

(b) No more than ninety calendar days after notification of changes in requirements in the data submission guide, the data supplier shall submit initial test files. This deadline may be extended by the lead organization when it determines that additional time will be needed in order for the change to be implemented.

(3) **Submission file.** Data and claim files shall be submitted to the WA-APCD on a quarterly basis. On or before April 30th, July 31st, October 31st and January 31st of each year, data and claim files shall be submitted for all nondenied adjudicated claims paid in the preceding three months.

(4) **Resubmission file.** Failure to conform to the requirements of this chapter or the data submission guide shall result in the rejection of the applicable data and claim files. The lead organization shall notify the data supplier when data and claim files are rejected. All rejected files must be resubmitted in the appropriate, corrected format within fifteen business days of notification unless a written request for an extension is received by the lead organization before the expiration of this fifteen business day period.

(5) **Claims run-out file.** If health care coverage is terminated for a Washington covered person, the data supplier shall submit data for a six month period following the health care coverage termination date.

(6) **Replacement file.**

(a) A data supplier may replace a complete data file, claim file or both data and claim file submission. Requests must be made to the lead organization with a detailed explanation as to why the replacement is needed. The lead organization shall make a recommendation to the office as to whether to approve or deny the request. The approval recommendation shall also state whether the approval is for the entire period requested or for a period less than requested.

(b) The office shall approve or deny the request and provide written notification to the requestor within thirty calendar days of receipt of the request. The office decision on the request for a replacement file will be provided in writing. If the office does not approve the complete request for a replacement file, the written notification will include the reason for the denial or approval of the shorter period of time.

(c) Requests may not be made more than one year after the end of the month in which the file was submitted unless the data supplier can establish exceptional circumstances for the replacement. The lead organization may recommend approval and the office may approve a request for more than one year for exceptional circumstances. The office shall approve or deny the request using the process set forth in (b) of this subsection.

NEW SECTION

WAC 82-75-060 Historical data submission. (1) The purpose of collecting historical data into the WA-APCD is to permit the systematic analysis of the health care delivery system including evaluation of the effectiveness of the Patient Protection and Affordable Care Act signed into law on March 23, 2010.

(2) The lead organization will provide written notification to the data suppliers when the WA-APCD is ready to accept the submission of historical data. Data suppliers shall submit the historical data within sixty days of notification. Requests for an extension of time to submit historical data shall be made in accordance with WAC 82-75-080(3).

(3) "Historical data" means covered medical services claim files, pharmacy claim files, dental claim files, member eligibility and enrollment data files, and provider data files with necessary identifiers for the period January 1, 2011, through December 31, 2015.

(4) The office may grant an exception to this section and approve the filing of historical data for a period less than the period specified in subsection (3) of this section. In no event will an exception be granted for a period beginning later than January 1, 2013. Requests for an exception under this subsection shall be made to the lead organization within fifteen calendar days of being notified in accordance with subsection (2) of this section. The lead organization shall make a recommendation to the office as to whether to approve or deny the request. The office may approve the request for good cause.

NEW SECTION

WAC 82-75-070 Data submission guide. (1) Data files and claim files shall be submitted to the WA-APCD in accordance with the requirements set forth in this chapter and the data submission guide.

(2) The lead organization shall develop the data submission guide with input from stakeholders. The lead organization shall develop a process to allow for stakeholder review and comment on drafts of the data submission guide and all subsequent changes to the guide. The office shall have final approval authority over the data submission guide and all subsequent changes.

(3) The lead organization shall notify data suppliers before changes to the data submission guide are final. Notification shall occur no less than one hundred twenty calendar days prior to the effective date of any change.

(4) Upon good cause shown, data suppliers may be granted an extension to comply with any changes to the data submission guide. Requests for extensions or exceptions shall be made in accordance with WAC 82-75-080.

NEW SECTION

WAC 82-75-080 Waivers and extensions. (1) The office may grant a waiver of reporting requirements or an extension of time to a reporting requirement deadline based on extenuating circumstances.

(2) **Waivers.**

(a) A data supplier may request a waiver from submission for a period of time due to extenuating circumstances affecting the data supplier's ability to comply with the reporting requirement for that period.

(b) The request shall be for no more than one reporting year and shall contain a detailed explanation as to the reason the data supplier is unable to meet the reporting requirements.

(c) A request for a waiver must be submitted to the lead organization at least sixty calendar days prior to the applicable reporting deadline. The lead organization shall make a recommendation to the office as to whether to approve or deny the request. The approval recommendation shall also state whether the approval is for the entire period requested or for a period less than requested.

(d) The office may approve a request for extenuating circumstances. Approval may be for a time period shorter than requested. The office shall approve or deny the request and provide written notification to the requester within thirty calendar days of receipt of the request. The office decision on the request for a waiver will be provided in writing. If the office does not approve a request for a waiver, the written notification will include the reason for the denial.

(3) **Extensions.**

(a) A data supplier may request an extension of time for submitting a quarterly report or the resubmission of a report due to extenuating circumstances affecting the data supplier's ability to submit the data by the deadline.

(b) The request shall be for no more than one reporting quarter and shall contain a detailed explanation as to the reason the data supplier is unable to meet the reporting requirements for that quarter.

(c) A request for an extension must be submitted to the lead organization at least thirty calendar days prior to the applicable reporting deadline unless the requestor is unable to meet this deadline due to circumstances beyond the data supplier's control. If unable to meet this deadline, the data supplier shall notify the lead organization in writing as soon as the data supplier determines that an extension is necessary.

(d) The lead organization shall make a recommendation to the office as to whether to approve or deny the request. The approval recommendation shall also state whether the approval is for the entire period requested or for a period less than requested.

(e) The office may approve a request for extenuating circumstances. The office shall approve or deny the request and provide written notification to the requestor within fifteen calendar days from when the lead organization receives the request from the data supplier. The office decision on the request for an extension will be provided in writing. If the office does not approve a request for an extension, the written notification will include the reason for the denial.

NEW SECTION

WAC 82-75-090 Penalties for failure to comply with reporting requirements. (1) The office may assess fines for failure to comply with the requirements of this chapter including, but not limited to:

- (a) General reporting requirements.
- (b) Health care claim files and data files requirements.
- (c) Health care claim files and data files submission requirements.

The office will not assess fines when the data supplier is working in good faith with the lead organization to comply with the reporting requirements.

(2) Unless the office has approved a waiver or extension, the office may assess a fine for failure to comply with general reporting requirements including, but not limited to, the following occurrences:

- (a) Failure to submit health care claim files or data files for a required line of business; and
- (b) Submitting health information for an excluded line of business.

(3) Unless the office has approved a waiver or extension, the office may assess a fine for failure to comply with health care claim file or data file requirements including, but not limited to, the following occurrences:

- (a) Submitting a health care claim or data file in an unapproved layout;
- (b) Submitting a data element in an unapproved format;
- (c) Submitting a data element with unapproved coding; and
- (d) Failure to submit a required data element.

(4) Unless the office has approved a waiver or extension, the office may assess a fine for failure to comply with health care claim file or data file submission requirements including, but not limited to, the following occurrences:

- (a) Failure to comply with WAC 82-75-050 (Data submission schedule);
- (b) Rejection of a health care claim or data file by the data vendor that is not corrected by the data supplier; and
- (c) Transmitting health care claim or data files using an unapproved process.

(5) Upon the failure to comply with a reporting requirement in this chapter, the office shall first issue a warning notice to a data supplier. The warning notice shall set forth the nature of the failure to comply and offer to provide assistance to the data supplier to correct the failure.

(6) A data supplier that fails to comply with the same reporting requirement in this chapter for which it previously received a warning notice, may be assessed a penalty of two hundred fifty dollars per day, not to exceed a maximum of twenty-five thousand dollars per occurrence. Each failure to comply with a reporting requirement for a reporting period is considered a separate occurrence.

(7) For good cause shown, the office may suspend in whole or in part any fine assessed in accordance with this section.

NEW SECTION

WAC 82-75-100 Administrative review. (1) Data suppliers may request an administrative review of an office decision to deny a request for an extension or waiver, or an assessment of a fine.

(2) A request for an administrative review may be initiated by a written petition filed with the office within thirty calendar days after notice of the denial or assessment of a fine. The petition shall include the following information:

(a) Data supplier's name, address, telephone number, e-mail address and contact person.

(b) Information about the subject of the appeal including remedy requested.

(c) A detailed explanation as to the issue or area of dispute, and why the dispute should be decided in the data supplier's favor.

(3) The petition and all materials submitted will be reviewed by the director or director's designee. The reviewing official may request additional information or a conference with the data supplier. A decision from the reviewing official shall be provided in writing to the data supplier no later than thirty calendar days after receipt of the petition. A denial of the petition will include the reasons for the denial.

NEW SECTION

WAC 82-75-110 Appeals. (1) A data supplier may request an appeal of a denial of its administrative review conducted in accordance with WAC 82-75-100.

(2) Request for an appeal must be submitted in writing to the office within fifteen calendar days after receipt of written notification of denial of its administrative review.

(3) Within ten business days of receipt of a written notice of appeal, the office will transmit the request to the office of administrative hearings (OAH).

(a) **Scheduling.** OAH will assign an administrative law judge (ALJ) to handle the appeal. The ALJ will notify parties of the time when any additional documents or arguments must be submitted. If a party fails to comply with a scheduling letter or established timelines, the ALJ may decline to consider arguments or documents submitted after the scheduled timelines. A status conference in complex cases may be scheduled to provide for the orderly resolution of the case and to narrow issues and arguments for hearing.

(b) **Hearings.** Hearings may be by telephone or in-person. The ALJ may decide the case without a hearing if legal or factual issues are not in dispute, the appellant does not request a hearing, or the appellant fails to appear at a scheduled hearing or otherwise fails to respond to inquiries. The ALJ will notify the appellant by mail whether a hearing will be held, whether the hearing will be in-person or by telephone, the location of any in-person hearing, and the date and time for any hearing in the case. The date and time for a hearing may be continued at the ALJ's discretion. Other office employees may attend a hearing, and the ALJ will notify the appellant when other of-

face employees are attending. The appellant may appear in person or may be represented by an attorney.

(c) **Decisions.** The decision of the ALJ shall be considered a final decision. Either party or both may file a petition for review of the final decision to superior court. If neither party files an appeal within the time period set by RCW 34.05.542, the decision is conclusive and binding on all parties. The appeal must be filed within thirty days from service of the final decision.