

Health Care Reimbursement Rate Data

Instructions for Reporting

Reporting Period: January 1, 2019, to December 31, 2019

Introduction

In 2007, the 80th Legislature passed SB 1731 to add Insurance Code Chapter 38, Subchapter H. The subchapter directs TDI to collect data relating to health benefit plan reimbursement rates in a uniform format and publish the resulting information on an aggregate basis for geographical regions within the state. In 2010, TDI adopted 28 TAC §§21.4501 – 21.4507 to implement the statute. In 2016, TDI made amendments to the rule to improve the data collection methodology.

The rule specifies which health benefit plan issuers are required to submit reimbursement rate data to TDI annually. TDI provides the following instructions as well as other resources located on the [Health Care Reimbursement Rate Data](#) page to help issuers collect the data and submit the reports.

Applicability

The data call applies to issuers offering private-market major medical group health coverage under Insurance Code Chapters 843 (Health Maintenance Organizations) or 1301 (Preferred Provider Benefit Plans). State employee health plans under Insurance Code Chapters 1551 (Texas Employees Group Benefits Act), 1575 (Texas Public School Employees Group Benefits Program), 1579 (Texas School Employees Uniform Group Health Coverage), and 1601 (Uniform Insurance Benefits Act for Employees of the University of Texas System and the Texas A&M University System) are also subject to reporting.

Issuers who report to the National Association of Insurance Commissioners (NAIC)¹ at least 20,000 covered lives as of the last day of the applicable reporting period are required to submit data. Only issuers who meet this threshold are required to submit data relating to reimbursement rates.

Issuers who **do not** meet the threshold are exempt and are **not** required to submit reports.

Report Submission

The reporting period is January 1, 2019, to December 31, 2019. The report is due by the close of business on Friday, May 1, 2020.

The following are the data submission requirements:

- Report data elements according to the medical billing target codes specified in the data template and limit claims as described in the query instructions.
- Report data separately for insurance and HMO business and exclude any HMO claims paid through a capitation agreement.

¹ NAIC Supplemental Health Care Exhibit – Part 1

- Report data separately for in-network and out-of-network claims.
- Limit data to only include:
 - claims incurred during the 12-month reporting period;
 - claims for which adjudication is final (exclude pending or denied claims);
 - claims for insureds in commercial fully insured plans or self-funded employer group plans;
 - claims for which the issuer is the primary plan responsible for payment (exclude claims for which the issuer is the secondary plan); and
 - claims with an allowed amount greater than zero.
- Submit reports in Microsoft Excel format.
- Submit reports by email to ReimbursementRates@tdi.texas.gov.

Data Publication

The requested data will allow TDI to publish probable expenses related to certain medical services and procedures or "treatment events." TDI will aggregate issuers' data before making it available to the public in the form of average costs a consumer is most likely to experience for treatment events. When data at the three-digit ZIP code prefix level includes too few claims to be statistically valid, or when it would reveal the negotiated prices of an individual issuer or provider, the data will be excluded or aggregated across a combination of three-digit ZIP code prefixes to represent a larger region.

Data Template

Each health benefit plan issuer required to report, or the issuer's designated agent, must submit the data to TDI in Microsoft Excel format using the data template located on the [Health Care Reimbursement Rate Data](#) page.

The data template has the following tabs:

- Introduction;
- Cover Page;
- Data;
- Query Instructions – Target Codes;
- Instructions;
- 3-digit ZIP;
- Example; and
- Data Identifiers Code Changes.

Introduction Tab

This tab provides general information about the data call including the TDI webpage and email address, due date, and rule reference.

Cover Page Tab

This tab is the cover page of the report and issuers must provide all requested information.

- **Reporting Period:** Enter the year for which data is being reported.
- **Company or Plan Name:** Enter the issuer's company name or the plan name if there is no company name.
- **NAIC Company Number:** Enter the issuer's NAIC company number or "n/a" if not applicable.

- **TDI Company Number:** Enter the issuer's TDI company number or "n/a" if not applicable.
- **Contact Information:** Enter the name of the person designated by the issuer or plan to discuss the report with TDI staff. Enter this person's direct telephone number and extension (if applicable) and email address. Indicate whether TDI may release this person's email address by checking either "yes" or "no."
- **Business Type:** Indicate whether the report is for health insurance business (PPO, EPO) or HMO business. Issuers must report reimbursement rate information separately for insurance and HMO business, regardless of whether a group health benefit plan issuer provides both insurance and HMO coverage under a single company number.
- **Reporting on Behalf of Governmental or Other Self-Insured Plans:** Indicate whether the report includes data for state employee plans or other self-insured business by checking one or more of the boxes. Issuers may submit data for self-funded plans separately or combine it with other data reported in this data call.
- **Certification of Data:** Confirm that the information provided in the report is a full and true statement of the data required and enter the name of the individual authorized by the issuer or plan to certify the data.
- **AMA License Agreement:** Acknowledge agreement with the AMA license agreement for the use of CPT² codes.

Data Tab

This tab provides the actual reporting template. Issuers may not have data to report for all of the data identifiers listed (rows). However, when reporting information for a data identifier, the issuer must provide all of the information for columns E through V with the exception of the number of discharges (G) which are only applicable to inpatient facility claims.

The data collected is specified by §21.4507. Using the query instructions and target codes, issuers will report data for each treatment event for the services or procedures listed. The template specifies instruction codes for each treatment event, which corresponds to a set of instructions or filters to use when building the data queries.

Issuers will report data separately for in-network and out-of-network claims in each three-digit ZIP code prefix. Generate a new row for each network status and three-digit ZIP code prefix pairing in which the issuer has responsive data. Populate the information in columns A through D without modifications for each new row generated—modifications will delay TDI's analysis of the data.

The data fields are listed below. The letters shown in the front of each field correspond to the columns of the data template.

- Data Identifier:** Provided by TDI; **do not** make modifications to the information.
- Treatment Event:** Provided by TDI; **do not** make modifications to the information.
- Data Component Description:** Provided by TDI; **do not** make modifications to the information.
- Instruction Code:** Provided by TDI; **do not** make modifications to the information.
- Network Status (IN or OON):** Report all data separately for in-network and out-of-network claims. Use "IN" to indicate in-network data and "OON" to indicate out-of-network data.

² CPT is a registered trademark of the American Medical Association.

- F. **3-Digit ZIP Code:** Report all data by the service provider's three-digit code prefix. The data template includes a tab listing the 52 three-digit ZIP code prefixes in Texas. Provide data for each three-digit ZIP code prefix in which applicable claims occur.
- G. **Number of Discharges:** *Only applicable for inpatient facility claims.* Report the total count of hospital discharges that reflect one unique inpatient stay. The number of stays might vary from the number of claims because each discharge could have multiple claims. This calculation could require aggregating claims that collectively report one inpatient stay or discharge.
- H. **Number of Claims:** Report the total count of unique claims from which the data is derived.
- I. **Total Billed Amount:** Report the aggregated dollar amount billed for the requested procedure for the total number of applicable claims (or discharges in the case of inpatient facility claims).
- J. **Total Allowed Amount:** Report the aggregated dollar amount allowed for the requested procedure for the total number of applicable claims (or discharges in the case of inpatient facility claims).
- K. **Mean Billed Amount:** Report the calculated mean dollar amount billed for the requested procedure for the total number of applicable claims (or discharges in the case of inpatient facility claims).
- L. **Mean Allowed Amount:** Report the calculated mean dollar amount allowed for the requested procedure for the total number of applicable claims (or discharges in the case of inpatient facility claims).
- M. **Median Billed Amount:** Report the median dollar amount billed for the requested procedure for the total number of applicable claims (or discharges in the case of inpatient facility claims).
- N. **Median Allowed Amount:** Report the median dollar amount allowed for the requested procedure for the total number of applicable claims (or discharges in the case of inpatient facility claims).
- O. **Maximum Billed Amount:** Report the maximum dollar amount billed for the requested procedure across all applicable claims (or discharges in the case of inpatient facility claims).
- P. **Maximum Allowed Amount:** Report the maximum dollar amount allowed for the requested procedure across all applicable claims (or discharges in the case of inpatient facility claims).
- Q. **Minimum Billed Amount:** Report the minimum dollar amount billed for the requested procedure across all applicable claims (or discharges in the case of inpatient facility claims).
- R. **Minimum Allowed Amount:** Report the minimum dollar amount allowed for the requested procedure across all applicable claims (or discharges in the case of inpatient facility claims).
- S. **25th Percentile Billed Amount:** Report the dollar amount billed for the requested procedure that marks the 25th percentile of billed amounts across all applicable claims (or discharges in the case of inpatient facility claims).
- T. **25th Percentile Allowed Amount:** Report the dollar amount allowed for the requested procedure that marks the 25th percentile of allowed amounts across all applicable claims (or discharges in the case of inpatient facility claims).
- U. **75th Percentile Billed Amount:** Report the dollar amount billed for the requested procedure that marks the 75th percentile of billed amounts across all applicable claims (or discharges in the case of inpatient facility claims).
- V. **75th Percentile Allowed Amount:** Report the dollar amount allowed for the requested procedure that marks the 75th percentile of allowed amounts across all applicable claims (or discharges in the case of inpatient facility claims).

Query Instructions-Target Codes Tab

This tab provides the following information for building queries to pull the data for the report:

- Procedure descriptions;
- Query instruction codes;
- Filters; and
- Primary, secondary, and exclusion target codes, as applicable.

Instructions Tab

This tab provides information about the following filters to pull the data for the report:

- **Filter 1** – Reporting year;
- **Filter 2** – Facility or Professional;
- **Filter 3** – Place of service/bill type institution, classification;
- **Filter 4** – CPT modifier;
- **Filter 5** – Units of Service;
- **Filter 6** – Identify claims with applicable target codes;
- **Filter 7** – 3-digit ZIP; and
- **Filter 8** – In-Network or Out-of-Network.

Refer to Appendix A for additional information about the filters.

3-Digit ZIP Tab

This tab provides a list of the 52 three-digit ZIP code prefixes in Texas.

Example Tab

This tab provides an example of what a completed report would look like.

Data Identifiers Code Changes Tab

This tab provides the list of data identifiers with code changes.

Definitions

- **Allowed amount** – The amount that the applicable health benefit plan issuer allows as payment for a health care service or group of services, including amounts for which a patient is responsible due to deductibles, copayments, or coinsurance.
- **Ambulatory surgical center** – A facility licensed under Health and Safety Code Chapter 243.
- **Applicable health benefit plan** – A group health benefit plan as specified in Insurance Code §38.352 and §38.353, which is a preferred provider benefit plan as defined by Insurance Code §1301.001, including an exclusive provider benefit plan consistent with Insurance Code §1301.0042; an evidence of coverage for a health care plan that provides basic health care services as defined by Insurance Code §843.002; or a state employee health plan under Insurance Code Chapters 1551, 1575, 1579, and 1601. The term does not include an HMO plan providing routine dental or vision services as a single health care service plan or a preferred provider benefit plan providing routine vision services as a single health care service plan.
- **Billed amount** – The amount charged for health care services on a claim submitted by a provider.
- **Facility claims** – Any claim for health care services provided by a facility as defined in 28 TAC §3.3702.

- **Freestanding emergency medical care facility** – Consistent with Health and Safety Code Chapter 254, a facility, structurally separate and distinct from a hospital that receives an individual and provides emergency care as defined by Insurance Code §1301.155.
- **Geographic region** – A three-digit ZIP code representing the collection of ZIP codes that share the same first three digits. For purposes of this data call, a geographic region must be located in Texas, in full or in part.
- **Imaging claims** – Claims for radiological services furnished in a provider office, outpatient hospital, or other outpatient environment.
- **Inpatient procedure claims** – Claims for health care services furnished in a hospital, as defined by Insurance Code §1301.001, to a patient who is formally admitted.
- **In-network claims** – Claims filed with an applicable health benefit plan for health care treatment, services, or supplies furnished by a provider contracted as an in-network or preferred provider under the plan.
- **Medical billing codes** – Standard code sets used to bill for specific medical services, including the Healthcare Common Procedure Coding System (HCPCS) and Diagnosis-Related Group (DRG) system established by the Centers for Medicare and Medicaid Services (CMS); the Current Procedural Terminology (CPT) code set maintained by the American Medical Association; and the International Classification of Diseases (ICD) code sets developed by the World Health Organization.
- **Modifier** – A modifier accompanies a CPT code and provides more information about the claim. For example, issuers must separately report imaging claims when claim lines are billed with a 26 modifier, which represents the professional component; a TC modifier, which represents the technical component; and a missing or null modifier. In select cases, other modifiers are included as secondary or exclusion target codes.
- **Out-of-network claims** – Claims filed with an applicable health benefit plan for health care treatment, services, or supplies furnished by a provider that is not an in-network provider or preferred provider under the plan. Claims paid on an out-of-network basis are considered out-of-network regardless of whether the provider is reimbursed based on an agreed rate.
- **Outpatient facility procedure claims** – Claims for health care services furnished in an ambulatory surgical center or a hospital, as defined by Insurance Code §1301.001, to a patient who is not formally admitted.
- **Place-of-service code** – A health care claim code where "place of service" refers to the type of entity where services were rendered, as specified by a two-digit place-of-service code on a professional health care claim consistent with the Accredited Standards Committee X12N (ASC X12N) standard for electronic transactions. CMS maintains place-of-service codes. Appendix B includes a subset of codes and descriptions. Refer to [CMS](#) for the complete list of codes.
- **Primary plan** – Consistent with 28 TAC §3.3503(17), a plan where benefits for a person's health care coverage must be determined without considering the existence of any other plan.
- **Professional claims** – Any claim for health care services provided by a physician or provider that is not an institutional provider, as defined in Insurance Code §1301.001.
- **Provider** – Any physician, practitioner, institutional provider, or other person or organization that furnishes health care services and is licensed or otherwise authorized to practice in Texas.
- **Reporting period** – The 12-month interval of time for which a plan or applicable health benefit plan issuer must submit data each year, beginning each January 1 and ending the following December 31.

- **Target codes** – The medical billing codes specified by TDI for identifying what claims information to report. The codes are on the Query Instructions – Target Codes tab of the data template located on the [Health Care Reimbursement Rate Data](#) page.
- **Total claim units** – The total number of final adjudicated separate claims for which an applicable health benefit plan issuer furnishes reimbursement for a specified medical billing code or group of codes. This term includes covered claims that attribute some or all of the reimbursement to patient responsibility such as deductibles, copayments, or coinsurance and excludes claims for which the applicable health benefit plan is a secondary plan.
- **Treatment event component** – The level at which data is collected, reflecting a component of the cost of providing a medical service or procedure within the scope of 28 TAC §21.4507(c) in a given place of service. A treatment event component generally corresponds to the separate bills a consumer might receive for a service or procedure, which may include a facility bill and one or more professional bills.
- **Unique claim ID** – An identifier that is specific to an individual claim for services provided to an insured. The number of unique claim IDs is used to indicate the number of separate encounters included in the total billed and allowed amount fields for a given code received in a specified three-digit ZIP code prefix.
- **Units of service** – The total number of units billed for a given medical billing code in a given three-digit ZIP code prefix. This term is a measure of medical services provided, such as the number of hospital days, minutes of anesthesia, or 15-minute increments of therapy.

Data Submission Instructions

Issuers or their authorized agents must submit the completed Microsoft Excel data template by email to ReimbursementRates@tdi.texas.gov. **TDI will not accept any reports submitted in a different format, including scanned PDF files.**

Questions?

Send questions about the reimbursement rate data call to ReimbursementRates@tdi.texas.gov.

Appendix A

The table below provides additional information about the filters to pull the data for the report.

Query Component		Notes
Filter 1	Reporting year	Filter 1 requires issuers to limit data to claims incurred during the applicable reporting period.
Filter 2	Facility or Professional	Filter 2 requires issuers to separately report facility and professional costs as appropriate. Each treatment event includes professional costs, and inpatient and outpatient procedures also include facility costs. Professional costs reflect services provided by physicians including surgeons, assistant surgeons, anesthesiologists, and pathologists. Facility costs reflect the cost of providing a surgical environment, advanced medical equipment, support staff, and administrative overhead.
Filter 3	Place of service; or bill type institution and bill type classification	Filter 3 requires issuers to limit data to services provided in a specific type of environment. Professional claims include a place-of-service code that indicates where the medical service was performed. Facility claims include information on the type of institution and an additional classification, which together distinguish the type of facility and whether the service was performed on an inpatient or outpatient basis.
Filter 4	CPT modifier	Filter 4 requires issuers to limit data to claims that include a specific CPT code modifier. These modifiers provide additional information and specificity about the medical service provided. This filter does not apply to all queries. In some cases, applicable CPT code modifiers are included as secondary or exclusion target codes.
Filter 5	Units of Service	Filter 5 requires issuers to limit data to claims where units of service equals one. This prevents the inclusion of claims that could skew the average billed or allowed amount reported. This filter does not apply to all queries.
Filter 6	Identify claims with applicable target codes	<p>Filter 6 instructs issuers on how to limit data to include specified primary, secondary, or exclusion target codes and whether to report data at the claim level or the claim line level. Some queries require issuers to compute the average amount per unit when reporting data for services that may be provided in multiple units of service.</p> <ul style="list-style-type: none"> - When Filter 6 specifies multiple primary target codes, the claim must include one or more of the codes listed. - When Filter 6 specifies the presence of a secondary target code, the claim must include one or more primary code(s) AND one or more secondary code(s). - When Filter 6 specifies the presence of an exclusion target code, data should be excluded if one or more of the exclusion target codes appear on the claim. That is, applicable claims must include the primary target code BUT NOT the exclusion target code.

Query Component		Notes
Filter 7	3-digit ZIP	Filter 7 requires that all queries separately report data for each 3-digit ZIP code prefix in which the issuer has applicable claims. The 3-digit ZIP code prefix for which data is being reported must be included in column F of the data tab worksheet.
Filter 8	In-Network or Out-of-Network	Filter 8 requires that all queries separately report in-network or out-of-network data. Column E of the data tab worksheet should indicate whether the data is being reported for in-network (IN) or out-of-network (OON) claims.

Appendix B

The table below includes a subset of place-of-service codes and descriptions. Refer to [CMS](#) for the complete list of codes.

Place-of-Service Code(s)	Place-of-Service Name	Place-of-Service Description
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
21	Inpatient Hospital	A facility, other than psychiatric, in which patients are provided with diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to persons who are but who do not require to be hospitalized or institutionalized.
23	Emergency Room – Hospital	A part of a hospital in which emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
72	Rural Health Clinic	A certified facility that is located in a rural, medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic or clinical tests independent of an institution or a physician's office.