SUBCHAPTER T. Submission of Clean Claims
28 TAC §21.2802 and §21.2803

1. INTRODUCTION. The Commissioner of Insurance adopts amendments to §21.2802 and §21.2803 concerning elements of a clean health care claim. Section 21.2803 is adopted with changes to the proposed text published in the January 19, 2007 issue of the *Texas Register* (32 TexReg 227). Section 21.2802 is adopted without changes.

2. REASONED JUSTIFICATION. The U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS), in conjunction with the National Uniform Claims Committee (NUCC) and the National Uniform Billing Committee (NUBC), has identified much of the information needed to process health care claims. Insurance Code §1204.102 requires a provider to use one of two forms, HCFA 1500 and UB-82/HCFA, or their successor forms, for submission of certain claims. Prior to this adoption, §21.2803 required usage of the CMS-1500 (12/90) form and the UB-92 CMS-1450 form for submission of certain clean claims. These adopted amendments are necessary to implement usage of two new successor forms, the CMS-1500 (08/05) and the UB-04 CMS-1450, and to establish data element requirements for use with those forms for clean claims that are filed pursuant to Insurance Code §§843.336 and 1301.131. These amendments are also necessary to address the phase-out of the two previous forms, the CMS-1500 (12/90) and the UB-92 CMS-1450, exclusively required for use in filing certain health care claims prior to this adoption. In accordance with §1212.002 of the Insurance Code, the amendments were developed

after consultation with the Technical Advisory Committee on Claims Processing (TACCP). The TACCP, which is appointed by the Commissioner, is comprised of representatives of insurers, health maintenance organizations, physicians and other health care providers, trade associations and other interested parties, such as the Office of Public Insurance Counsel. The TACCP advises the Commissioner on processing by insurers and health maintenance organizations of health care service claims submitted by physicians and other health care providers.

Following publication of the proposed amendments in the *Texas Register* on January 19, 2007, the Department received written comments from interested parties. The Department held a hearing on February 22, 2007, at which the Commissioner heard testimony and the Department received additional written comments. The Department has not made any changes to the proposed text as a result of comments. However, the Department has made necessary changes to the proposed text to more closely align timelines for mandatory form usage and national provider identifier (NPI) usage for clean claims with the most recent timelines that CMS is implementing for the same forms and identifier and for consistency with the effective date of this adoption. None of these changes materially alter issues raised in the proposed rule, introduce new subject matter, or affect persons other than those previously on notice.

On March 16, 2007, the NUCC notified the health care industry regarding the discovery of formatting errors on some of the revised CMS-1500 (08/05) claim forms and form negatives that had been distributed and advised that the incorrect forms were

not scanning properly. As a result, CMS extended its acceptance period of the CMS-1500 (12/90) form beyond the original April 1, 2007, deadline, delaying mandatory use of the CMS-1500 (08/05) form for certain nonelectronic Medicare claims. (*CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 1208, Change Request 5568* (CMS, March 19, 2007)). CMS has since issued notice instructing Medicare contractors to begin rejecting claims received on or after July 2, 2007 on claim form CMS-1500 (12/90). (*CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 1247, Change Request 5616* (CMS, May 25, 2007)).

Further, on April 2, 2007, CMS issued a *Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule After the May 23, 2007, Implementation Deadline* (*Guidance*). (http://www.cms.hhs.gov (follow "(NPI) Compliance Contingency Guidance" hyperlink)). The CMS *Guidance* indicated that the U.S. Department of Health and Human Services (DHHS) has received numerous inquiries raising concerns about the health care industry's state of readiness for NPI implementation. CMS, charged by the DHHS Secretary with enforcement of the NPI standard, therefore announced via the *Guidance* that in enforcing the NPI standard, CMS will consider the good faith efforts of a covered entity to comply with the NPI standard. The CMS *Guidance* contemplates the use of contingency plans to ensure the smooth flow of payments, provided the covered entity can demonstrate to CMS its active outreach and testing efforts toward full compliance. Under the CMS *Guidance*, a covered entity may

end its contingency plan at any time prior to May 23, 2008, but cannot continue it after that date.

To more closely align the timelines for usage of successor forms required in this adoption with the timelines being implemented by CMS, and in recognition of the need for sufficient time to resolve issues related to the printing and distribution of error-free forms and form negatives, the Department has changed the timelines in proposed §21.2803(b)(1) – (4) for implementation of the CMS-1500 (08/05) and UB-04 CMS-1450 forms for clean claims.

Proposed §21.2803(b)(1) required use of the CMS-1500 (08/05) form for physicians and noninstitutional providers for clean claims filed or re-filed on or after April 2, 2007. Proposed §21.2803(b)(1) also established an optional transition period for claims filed or re-filed prior to April 2, 2007, upon notification by a preferred provider carrier or HMO that it was prepared to accept claims on the CMS-1500 (08/05). Section 21.2803(b)(1) as adopted mandates the use of successor form CMS-1500 (08/05) for physicians and noninstitutional providers for nonelectronic claims filed on or after the later of two dates: July 18, 2007, or the earliest compliance date established by CMS for mandatory use of the CMS-1500 (08/05) form for Medicare claims. If transition by CMS to mandatory usage of the CMS-1500 (08/05) claim form on and after July 2, 2007 is effected, adopted §21.2803(b)(1) requires physicians and noninstitutional providers submitting nonelectronic claims pursuant to Insurance Code §§ 843.336 and 1301.131 to use the CMS-1500 (08/05) claim form for claims filed or re-filed on or after July 18,

2007 for clean claims. The Department has also modified the optional timeline for earlier transition set forth in proposed §21.2803(b)(1) for consistency with the new mandatory use timeline such that a physician or noninstitutional provider may file or re-file a claim on the CMS-1500 (08/05) form earlier than the new mandatory use timeline. The optional usage timeline is contingent upon notification by a preferred provider carrier or HMO that it is prepared to accept claims on the CMS-1500 (08/05). For consistency, the Department has similarly modified the timelines in proposed §21.2803(b)(2) for mandatory use and earlier optional transition with regard to the CMS-1500 (12/90) form. Proposed §21.2803(b)(3) required use of the UB-04 CMS-1450 for institutional providers for clean nonelectronic claims filed or re-filed on or after May 23, 2007, and provided for an optional transition period for claims filed between March 1, 2007 and May 22, 2007, upon notification by a preferred provider carrier or HMO that it was prepared to accept claims on the UB-04 CMS-1450. In §21.2803(b)(3) as adopted, the Department has changed the timelines for mandatory use of the UB-04 CMS-1450 for consistency with the effective date of this adoption order. New §21.2803(b)(3) as adopted mandates the use of successor form UB-04 CMS-1450 for institutional providers for nonelectronic claims filed on or after July 18, 2007. This mandatory usage date is consistent with CMS mandatory usage dates that require use of the UB-04 CMS-1450 form for certain nonelectronic Medicare claims on and after May 23, 2007. (*CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 1104, Change Request 5072* (CMS, November 3, 2006)). The Department has similarly modified the

optional earlier transition timeline set forth in proposed §21.2803(b)(3) for consistency with the new mandatory use timeline. Under new §21.2803(b)(3), an institutional provider may file or re-file a claim on the UB-04 CMS-1450 prior to the new mandatory use timeline upon notification that a preferred provider carrier or an HMO is prepared to accept claims filed on that form. For consistency, the Department has similarly modified the timelines in proposed §21.2803(b)(4) for mandatory use and earlier optional transition with regard to the UB-92 CMS-1450 form. The Department will continue to monitor developments at CMS relating to the usage of the two new successor forms and will issue an information bulletin to provide additional clarification regarding the CMS mandatory use date for the CMS-1500 (08/05) form when CMS effects the final transition.

Further, to support but not anticipate federal implementation and enforcement of the NPI standard, the Department has changed the proposed required date for submission of the NPI as a data element from May 23, 2007 to May 23, 2008. Specifically, the Department has made this change at §21.2803(b)(1)(W), (GG), (NN), and (PP), and (3)(CC) and (OO). In making this change, the Department recognizes the CMS *Guidance* regarding contingency plans and good faith implementation of the NPI standard.

No other changes are made to the proposed amendments to §21.2803 published in the January 19, 2007, edition of the *Texas Register*. The amendments to §21.2802(3) and (16) – (33), concerning definitions, are necessary to define the NPI

number, a standard unique health identifier number for health care providers assigned pursuant to federal law for which the NUCC and NUBC have created specific information fields in the new successor forms. The amendments are also necessary to update statutory references related to the enactment of the nonsubstantive Insurance Code revision and to renumber subsequent definitions in accordance with the new definition for "NPI number."

Several amendments are made to §21.2803 which address the elements of a clean claim. The amendment to §21.2803(a)(2) is necessary to correct an internal cross-reference. The amendments to §21.2803(b) are necessary to identify new successor forms required for the submission of nonelectronic health care claims by physicians and providers and to establish mandatory form usage dates and optional form transition date(s) for those forms and for the predecessor forms.

The amendments throughout §21.2803(b) include editorial clarifications. The Department has amended subparagraphs 21.2803(b)(1)(H) – (L) and (Q), which require submission of documented proof with the claim in certain specified instances, by deleting the phrase "to the HMO or preferred provider carrier." Although the former rule regarding those data elements contains this phrase, the language is unnecessary because these subparagraphs already specify that, when required according to the instructions in those subparagraphs, the physician or provider must submit *with the claim* documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information

needed to complete the data element. This change is consistent with adopted amendments to address the corresponding data elements in §21.2803(b)(2)(H) – (L) and (Q), regarding required data elements for the CMS-1500 (12/90) form during the phase-out of that form, and does not substantively change requirements regarding these data elements. New §21.2803(b)(1)(U) is necessary to clarify the circumstances in which a physician or provider must enter the name of a referring primary care physician, specialty physician, hospital, or other source of referral, and does not effect a substantive change. New §21.2803(b)(1)(V) similarly clarifies the circumstances in which a physician or provider must submit the ID number of the referring primary care physician, specialty physician, or hospital. Because the physician or provider should already have submitted an entry affirming the nonexistence of a referring provider in field 17 when appropriate, the adopted rule does not require duplication of this information in field 17a.

New §21.2803(b)(1)(W) is necessary to require that, for claims filed or re-filed on or after May 23, 2008, if there is a referring physician noted in field 17, the physician or provider filing the claim must enter the NPI number of the referring primary care physician, specialty physician, or hospital, if the referring physician is eligible for an NPI number. New §21.2803(b)(1)(GG), (NN), and (PP) address similar NPI submission requirements for rendering providers, facilities, and billing providers. This NPI number usage requirement is consistent with the CMS *Guidance* regarding requirements and timelines for standard transactions and will support but not anticipate federal

implementation and enforcement of the NPI number standard. This usage requirement ultimately allows for greater consistency between standard and nonstandard transactions. Further, this usage requirement strengthens the ability of physicians and providers to submit clean electronic claims by promoting the use of the NPI number in nonstandard transactions.

In addition to accommodating the CMS *Guidance* regarding NPI implementation in standard transactions, new §21.2803(b)(1) recognizes that the *CMS Final Rule for HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers, Subpart D*, does not require a small health plan to comply with implementation specifications for use of the NPI number until May 23, 2008. New §21.2803(b)(1)(V), therefore, requires submission of the ID number of the referring primary care physician, specialty physician, or hospital as applicable. The adoption of §21.2803(b)(1)(V) is a continuation of the requirement applicable to the predecessor form CMS-1500 (12/90) and enables health plans to continue to identify physicians without reference to the NPI number. Similarly, and for the same reasons, new §21.2803(b)(1)(QQ) continues the requirement for submission of the rendering provider number if the HMO or preferred provider carrier required provider numbers and notified physicians and providers of the requirement prior to June 17, 2003. New §21.2803(b)(1)(OO) and (QQ) further reflect that information previously captured together in the single field 33 on form CMS-1500 (12/90) now has discrete subfields in successor form CMS-1500 (08/05).

Consistent with usage recommendations of the NUCC in the *1500 Health Insurance Claim Form Reference Instruction Manual for 08/05 Version, Version 2.1 (3/07)* (NUCC Manual), new §21.2803(b)(1)(MM) requires a physician or provider to submit the name and address of the facility where services are rendered, if other than home, rather than if other than home or office.

Adopted amendments throughout §21.2803 change references to CMS-1500 (12/90) to distinguish the form from successor form CMS-1500 (08/05).

The adopted amendment to §21.2803(b)(2)(U) is necessary to clarify the circumstances in which a physician or provider must enter the name of a referring primary care physician, hospital, or other source of referral, and does not effect a substantive change. The adopted amendment to §21.2803(b)(2)(V) similarly clarifies the circumstances in which a physician or provider must submit the ID Number of the referring primary care physician, specialty physician, or hospital.

New §21.2803(b)(3)(C) requires submission of the type of bill code, including submission of a "7" in the fourth position of the UB-04 field 4 if the claim is a corrected claim. This requirement, which varies from the requirement to submit a "7" in the third position for the UB-92, is necessary because the UB-04 form now accommodates type of bill codes in the first three digits of the field and utilizes the fourth position of field 4 to report frequency of the bill.

New §21.2803(b)(3) reflects the NUBC’s reorganization/renumbering of field assignments on the UB-04 form. Field identifications have therefore been updated

throughout the paragraph in accord with the new field assignments. Further, §21.2803(b)(3) does not include marital status, submission of the procedure coding method used, or signature of the provider representative as required data elements for the UB-04 form. While the Department requires submission of this information on the predecessor form, the new UB-04 form no longer contains assigned fields for these purposes. Because the UB-04 form no longer contains a field assignment for prior patient payments, new §21.2803(b)(3) does not include this data element. Section 21.2803(b)(3) as adopted also does not set forth discrete data element requirements for covered days; non-covered days; coinsurance days; or lifetime reserve days, as are required for the UB-92 form. The UB-04 form no longer contains assigned fields for these specific purposes. Instead, a clean noninstitutional provider claim must include value codes corresponding to this information as appropriate and as set forth in §21.2803(b)(3)(S).

New §21.2803(b)(3)(CC) is necessary to require that an institutional provider submit the billing provider's NPI number for claims filed or re-filed on or after May 23, 2008, if the billing provider is eligible for an NPI number. New §21.2803(b)(3)(OO) contains a similar NPI number submission requirement for the attending physician. This NPI number usage requirement is consistent with the CMS *Guidance* regarding requirements and timelines for standard transactions and supports but does not anticipate federal implementation and enforcement of the NPI number standard. Ultimately, this usage requirement allows for greater consistency between standard and

nonstandard transactions. Further, this usage requirement strengthens the ability of institutional providers to submit clean electronic claims by promoting the use of the NPI number in nonstandard transactions.

Consistent with the adopted rule regarding the required clean claim elements for the CMS-1500 (08/05) form, new §21.2803(b)(3)(DD) requires an institutional provider to submit the payor-designated provider number if the HMO or preferred provider carrier required provider numbers and gave notice of that requirement to physicians and providers prior to June 17, 2003. Similarly, new §21.2803(b)(3)(PP) requires institutional providers to submit the payor-designated attending physician ID. These requirements are a continuation of the requirements applicable to the predecessor form UB-92 and are necessary to enable health plans to continue to identify these providers without reference to the NPI number.

The adopted amendment to §21.2803(b)(4)(LL) is necessary to delete a repetitive reference. The adopted amendments to §21.2803(d), relating to coordination of benefits and non-duplication of benefits, are necessary to update internal cross-references and specify required elements necessary for a secondary plan to process claims in accordance with the applicable form.

The amendments throughout §21.2803 further address clarifications necessary to update internal cross-references and correct minor punctuation and grammatical errors.

3. HOW THE SECTIONS WILL FUNCTION. The adopted amendment to §21.2802(16) adds a definition for the NPI number, a standard unique health identifier number for health care providers assigned pursuant to federal law for which the National Uniform Billing Committee and the National Uniform Claims Committee have created specific information fields in the new successor forms.

The adopted amendment to §21.2803(a)(2) corrects a reference to clarify that a physician or provider submits a clean electronic claim, including a clean electronic dental claim filed with an HMO, by providing to the specified carrier the required data in compliance with the requirements in §21.2803(e) and (f).

The adopted amendments to §21.2803(b) mandate usage of certain successor forms for specified claims; establish optional timelines to allow for transition to the new forms; establish required usage dates; and establish the data elements required for a physician or provider to submit a clean claim. The adopted amendments to §21.2803(b)(1) redesignate former subsection (b)(1) as subsection (b)(2) and add a new subsection (b)(1). The new §21.2803(b)(1) mandates the use of CMS-1500 (08/05) form for physicians and noninstitutional providers for nonelectronic claims filed or re-filed on or after the later of two dates: July 18, 2007, or the earliest compliance date established by CMS for mandatory use of the CMS-1500 (08/05) form for Medicare claims. New §21.2803(b)(1) also sets forth the data elements that physicians and noninstitutional providers must complete in accordance with that paragraph for clean claims. New §21.2803(b)(1) further provides for an optional transition period prior to the

mandatory usage date. Upon notification by an HMO or a preferred provider carrier that it is prepared to accept claims filed or re-filed prior to the mandatory usage date on form CMS-1500 (08/05), a physician or non-institutional provider may submit claims using that successor form, subject to the data element requirements set forth in the paragraph for clean claims for form CMS-1500 (08/05). New §21.2803(b)(1)(A) – (QQ) specifies the field location of those data elements on successor form CMS-1500 (08/05).

The adopted amendments to redesignated §21.2803(b)(2) (subsection (b)(1) in the former rule) address the phase-out period of form CMS-1500 (12/90). The amendments specify that physicians and noninstitutional providers filing or re-filing nonelectronic claims prior to the earlier of two dates, July 18, 2007, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (08/05) form for Medicare claims, must use predecessor form CMS-1500 (12/90). The adopted amendments continue the data element requirements applicable to the CMS-1500 (12/90) form for clean claims. The amendments further provide that, upon notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on form CMS-1500 (08/05), a physician or noninstitutional provider may submit claims using form CMS-1500 (08/05) prior to the §21.2803(b)(1) mandatory usage date, subject to the required data elements set forth in new §21.2803(b)(1).

The adopted amendments to §21.2803(b)(3) redesignate former subsection (b)(2) as subsection (b)(4) and add a new subsection (b)(3). New §21.2803(b)(3) mandates the use of successor form UB-04 CMS-1450 for institutional providers for

nonelectronic claims filed or re-filed on or after July 18, 2007, and sets forth the data elements that institutional providers must complete in accordance with this paragraph for clean claims. An optional transition period is provided under adopted §21.2803(b)(3), allowing for use of form UB-04 CMS-1450 prior to the mandatory usage date established in §21.2803(b)(3). Prior to the §21.2803(b)(3) mandatory usage date, upon notification from an HMO or preferred provider carrier that it is prepared to accept claims filed or re-filed on the new successor form, an institutional provider may submit claims using successor form UB-04 CMS-1450, subject to the data elements set forth in §21.2803(b)(3) for clean claims.

The adopted amendments to redesignated §21.2803(b)(4) (subsection (b)(2) in the former rule) address the phase-out period for form UB-92 CMS-1450. The amendments require that institutional providers filing or re-filing nonelectronic claims prior to July 18, 2007, must use predecessor form UB-92. The amendments continue the data element requirements applicable to that form for clean claims. The amendments further provide that upon notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on form UB-04 earlier than the §21.2803(b)(3) mandatory usage date, the institutional provider may submit claims using the UB-04 CMS-1450 form prior to the §21.2803(b)(3) mandatory usage date, subject to the data element requirements established in §21.2803(b)(3) for clean claims.

The adopted amendments to §21.2803(d), relating to coordination of benefits and non-duplication of benefits, update internal cross-references and specify required data

elements necessary for a secondary plan to process claims in accordance with the applicable form.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General Comments

Comment: Commenters commend the Department for its diligence and effort to adopt rules necessary to accommodate the revision of the information fields set forth in the two new successor forms, the CMS-1500 (08/05) and the UB-04 CMS-1450. Some commenters generally agree with the proposed amendments to coordinate the modifications required by the implementation of the federally-mandated National Provider Identifier with the state requirements for submission of clean claims on the successor forms. One commenter further commended the Department for its work with the Technical Advisory Committee on Claims Processing (TACCP) in evaluation of draft rules and consideration of the committee's recommendations.

Agency Response: The Department appreciates the comments. The Department has given close consideration to federal implementation efforts with regard to the National Provider Identifier in adopting the rule.

Comment: One commenter expresses appreciation that the Department has restricted its rulemaking proposal to only those issues necessary to transition to the new claim formats because, according to the commenter, the need for smooth transition to the

new forms outweighs any benefit that would be gained from further changes in the data element requirements.

Agency Response: The Department appreciates the comment. Most of the data element requirements in new §21.2803(b)(1) and (b)(3) are consistent with those data element requirements previously identified for use in clean claims on the predecessor forms. The Department will monitor the need for future rulemaking with regard to additions, deletions, or changes to data element requirements.

§21.2803(b)(1) and (2)

Comment: A commenter supports the proposed timelines for use of the CMS-1500 (08/05) form and the transition period during which either the 08/05 version or the 12/90 version of the CMS-1500 claim form may be submitted. The commenter states that the proposed rules allow use of either version of the CMS-1500 form in the period between final adoption of the proposed rules and April 2, 2007, and require use of the CMS-1500 (08/05) form on or after April 2, 2007. The commenter states that these timelines are consistent with those adopted by CMS, the federal agency charged with oversight of the Medicare program.

Agency Response: The Department appreciates the supportive comment and clarifies that a claim filed or re-filed prior to the §21.2803(b)(1) mandatory usage date for the CMS-1500 (08/05) form will not qualify as a potential clean claim absent prior notification from the HMO or preferred provider carrier that it is prepared to accept

claims filed or re-filed on the CMS-1500 (08/05) form. Based upon recent changes to CMS timelines for mandatory use of the CMS-1500 (08/05) form with regard to Medicare claims and errors related to the printing and distribution of improperly formatted forms and form negatives, the Department has had to revise its timelines in order to more closely align those timelines with federal implementation. Adopted §21.2803(b)(1) requires physicians or noninstitutional providers filing or re-filing nonelectronic claims to use the CMS-1500 (08/05) form on or after the later of July 18, 2007, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (08/05) form for Medicare claims, in accordance with the special instructions applicable to the data elements described in §21.2803(b)(1) for clean claims. Further, adopted §21.2803(b)(1) provides that a physician or noninstitutional provider may file or re-file a nonelectronic claim using the CMS-1500 (08/05) form earlier than the §21.2803(b)(1) mandatory use date, subject to the §21.2803(b)(1) required data elements for clean claims, upon notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on form CMS-1500 (08/05). Similarly, adopted §21.2803(b)(2) requires physicians and noninstitutional providers filing or re-filing nonelectronic claims before the later of July 18, 2007, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (08/05) form for Medicare claims, to use the CMS-1500 (12/90) form, in accordance with the special instructions applicable to the data elements described in §21.2803(b)(2) for clean claims. Adopted §21.2803(b)(2) also provides, however, that a physician or noninstitutional provider may

file or re-file a nonelectronic claim using the CMS-1500 (08/05) form earlier than the §21.2803(b)(1) mandatory use date, subject to the §21.2803(b)(1) required data elements for clean claims, upon notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on form CMS-1500 (08/05).

§21.2803(b)(1), (2), (3), and (4)

Comment: A commenter states that carriers using automated clean claim compliance processes will find it more difficult to use multiple clean claim formats and seeks confirmation that a carrier may begin accepting the new claim forms prior to the mandatory usage dates without communicating to providers that the new forms will be treated as clean claims. According to the commenter, while the carrier may be able to accept claim information in multiple formats and process the claim with sufficient information, the carrier may be limited in its ability to treat multiple claim formats as clean. The commenter seeks clarification that mere acceptance of a new claim format prior to the mandatory usage date for the new forms does not require the carrier to treat the claim as a clean claim even if all necessary fields are completed. The commenter requests that communication by a carrier that it is able to treat the new claim formats as clean claims should serve as the necessary notice required in the adopted rule to allow for optional earlier transition to the new forms.

Agency Response: The Department clarifies that the optional transition periods for submission of the CMS-1500 (08/05) form and the UB-04 CMS-1450 form do not apply

absent notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on the respective successor forms. If an HMO or preferred provider carrier notifies physicians and providers that it is prepared to accept claims on these successor forms prior to the mandatory usage dates, the HMO or preferred provider carrier must comply with its prompt pay obligations with respect to such claims. Mere acceptance and processing of a claim on the successor form prior to the mandatory usage date for the successor form will not require the carrier to treat the claim as a potential clean claim if the carrier has not notified physicians and providers that the carrier is prepared to accept the new claim format.

Comment: A commenter requests clarification that acceptance of a claim on the predecessor claim forms after the mandatory usage date for filing and re-filing of claims on the CMS-1500 (08/05) form and the UB-04 CMS-1450 form does not impose a requirement to treat such claims as clean even if all necessary fields are completed.

Agency Response: The Department clarifies that a physician or provider who files or re-files a non-electronic claim after the mandatory usage dates for the CMS-1500 (08/05) form and the UB-04 CMS-1450 form must submit the claim on the applicable claim form, subject to the data element requirements set forth in §21.2803(b)(1) and (b)(3), in order for the claim to be clean. Mere acceptance and processing of a claim submitted on the predecessor form after the mandatory usage dates does not impose a requirement to treat such claims as potentially clean claims.

§21.2803(b)(1)(U) and (V)

Comment: A commenter states that it has on several occasions urged the Department to revise the requirements for CMS-1500, fields 17 and 17a, regarding the name of a referring physician or other source and the ID number of the referring physician, respectively. The data element requirements for these fields for the predecessor form required submission of the name and identification number of the referring physician or, absent a referral, entry of the term "Self-referral" or "None." The commenter asserts that the fields should be conditional and therefore left blank if there is not a referring physician. The commenter supports the proposed change designating CMS-1500 (08/05), fields 17a and 17b as conditional and not requiring entry of the term "Self-referral" or "None" when there is no referring physician. The commenter states that field 17 should similarly be a conditional field.

Agency Response: The Department appreciates the supportive comment but declines to make the suggested change. Section 21.2803(b)(1)(U) continues the requirement that a physician or provider affirm the nonexistence of a referring primary care physician, specialty physician, hospital or other source by entering the term "Self-referral" or "None" in field 17 when applicable. Carriers have indicated that this requirement facilitates claims processing by affirming that the billing party has not simply failed to make an entry in the field. However, in recognition that this affirmation is already required in field 17 and therefore would be duplicative if repeated, new §21.2803(b)(1)(V) does not require resubmission of this entry for the referring entity’s ID

Number. The Department will monitor the continued need for this data element for possible future rulemaking.

§21.2803(b)(1)(X)

Comment: A commenter notes that under the proposed rule, CMS-1500 (08/05), field 19 continues to be a conditional field to be completed when a physician uses an unlisted or not classified procedure code or a National Drug Code. The commenter is not opposed to continued use of this field in this manner and does not think such use is inconsistent with the NUCC Manual recommendations. The commenter requests clarification of whether submission of supplemental information consistent with the NUCC Manual instruction would render a claim deficient. The commenter asserts that submission of the supplemental information in field 24 would constitute submission of data elements or information on or with a claim form by a physician or provider that are in addition to those required for a clean claim as described in §21.2803(h) and would not, therefore, render the claim deficient.

Agency Response: The Department clarifies that the use of field 24 on the CMS-1500 (08/05) form in a manner consistent with the NUCC Manual instruction for that field would not, in and of itself, render a claim deficient. The commenter is correct that §21.2803(h) clarifies that the submission of data elements or information on or with a claim form by a physician or provider in addition to those required for a clean claim under the section shall not render the claim deficient.

§21.2803(b)(1)(QQ)

Comment: A commenter notes that the proposed rule requires the use of a legacy identifier issued by a health plan for which notice was given prior to June 17, 2003, in field 33b, CMS-1500 (08/05). The commenter states that the proposed rule is consistent with the corresponding data element requirement for field 33 on claim form CMS-1500 (12/90), which the commenter states identifies medical groups for which a health plan has assigned a legacy identification number. The commenter states that a medical group's identification number is often used when individual physicians and other healthcare professionals provide services under a health plan contract with a medical group. The commenter further asserts that because medical groups may apply and receive a Type 2 NPI to identify themselves as an entity separate from the individual provider, the continued requirement of the legacy identifier for the billing provider is superfluous and should only be required if the billing provider is not eligible for an NPI.

Agency Response: The Department declines to make the suggested change. The CMS Final Rule for HIPAA Administrative Simplification regarding the NPI does not require a small health plan to comply with NPI usage requirements until May 23, 2008. Further, based upon the CMS *Guidance* contemplating the use of NPI contingency plans until May 23, 2008, imposition of an earlier requirement for NPI does not appear to be advisable at this time. The adopted amendment therefore requires submission of

the ID number of the billing providers in certain circumstances so that health plans can identify those billing providers without reference to the NPI.

§21.2803(b)(3)(N)

Comment: A commenter recommends striking the requirement for submission of the discharge hour in field 16 of the UB-04 for outpatient surgeries or observation stays and limiting the requirement to inpatient admissions as recommended by the NUBC in its *National Uniform Billing Committee Official UB-04 Data Specifications Manual 2007* (NUBC Manual).

Agency Response: The Department declines to make the suggested change. The Department consulted with the TACCP regarding the specific changes to this data element requirement recommended by the commenter and asked for consideration of how such changes would affect claims processing. The response from carrier representatives indicates that the discharge hour for outpatient surgeries and observation stays continues to have importance to claims processing by the carrier. The Department will, however, monitor the continuing need for this data element and consider future rulemaking as necessary.

§21.2803(b)(3)(S)

Comment: A commenter recommends striking both the inpatient admission requirement for use of value codes and amounts and the permissive language that

allows providers to use a value code of "01." The commenter states that the value code and amount data elements in fields 39 through 41 of the UB-04 should only be completed when the value code is applicable to the claim or encounter as recommended in the NUBC Manual.

Agency Response: The Department declines to make the suggested change. Under the rule, a provider may indicate that no value code applies to the inpatient admission by entering a value of "01." The Department consulted with the TACCP regarding the specific changes to this data element requirement recommended by the commenter and asked for consideration of how such changes would affect claims processing. The response from one provider is consistent with that submitted by the commenter. Response from carrier representatives, however, indicates opposition to the suggested changes. Carrier representatives indicate that the inpatient admission requirement continues to be appropriate and assert that a provider's affirmation that no value code applies to the claim facilitates claim processing. The carrier representatives assert that the affirmation evidences that the provider did not inadvertently leave the field blank. The Department will monitor the continuing need for this data element and consider future rulemaking as necessary.

§21.2803(b)(3)(T)

Comment: A commenter recommends changing the requirement for submission of a revenue code in UB-04, field 42 to achieve greater alignment with the NUBC Manual

recommendations by requiring that "revenue code… is required for inpatient services and for outpatient services, the corresponding HCPCs code should be reported."

Agency Response: The Department declines to revise proposed §21.2803(b)(3)(T) as the commenter recommends. Section 21.2803(b)(3)(V) addresses data element requirements related to HCPCs. Further, §21.2803(h) clarifies that the submission of data elements or information on or with a claim form by a physician or provider in addition to those required for a clean claim under the section shall not render the claim deficient. A provider is therefore not precluded from submitting additional information on a voluntary basis. The Department will monitor whether carriers need additional information related to field 42 for claims processing and will consider future rulemaking as necessary.

§21.2803(b)(3)(V)

Comment: A commenter recommends that the Department more closely follow NUBC Manual recommendations for UB-04, field 44 by requiring submission of HCPCS/Rates/HIPPS codes for outpatient claims when an appropriate HCPCS or HIPPS code exists for the service line item, or for inpatient claims when an appropriate HCPCS code for drugs and/or biologics or a HIPPS code exists for the service line item.

Agency Response: The Department declines to make the suggested change at this time. Section 21.2803(h) clarifies that the submission of data elements or information on or with a claim form by a physician or provider in addition to those required for a

clean claim under the section shall not render the claim deficient. A provider is therefore not precluded from submitting additional information on a voluntary basis. However, the Department will monitor whether any changes to the circumstances in which HCPCs and rate information should be required becomes appropriate, as well as whether carriers need additional information related to field 44 for claims processing, and will consider future rulemaking as necessary.

§21.2803(b)(3)(X)

Comment: One commenter recommends that the Department more closely follow NUBC Manual recommendations for UB-04, field 45, line 23, by referring to the "creation date" rather than the date the bill was submitted and by requiring the submission of this information on all pages of the UB-04 form.

Agency Response: The Department declines to make the suggested change. The phrase "date bill submitted" as used in the rule clearly conveys the information that a provider must enter in this field. Additionally, §21.2803(h) clarifies that the submission of data elements or information on or with a claim form by a physician or provider in addition to those required for a clean claim under the section shall not render the claim deficient. A provider is therefore not precluded from submitting additional information on a voluntary basis. The Department will monitor whether changes in submission requirements related to field 45 become necessary for claims processing and will consider future rulemaking as necessary.

§21.2803(b)(3)(MM)

Comment: A commenter recommends that the Department more closely align its rule with NUBC Manual recommendations for UB-04, field 74, by deleting the application of this requirement regarding principal procedure codes for purposes of outpatient surgical procedures.

Agency Response: The Department declines to make the suggested change. The Department consulted with the TACCP regarding the specific changes to this data element requirement recommended by this commenter and asked for consideration of how such changes would affect claims processing. Response submitted by carriers pursuant to that request indicates that principal procedure code information continues to be necessary for claims processing of both inpatient and outpatient claims. The Department will, however, continue to monitor the need for future rulemaking with regard to this data element.

§21.2803(b)(3)

Comment: One commenter recommends that the Department more closely align its rule with NUBC Manual recommendations for the UB-04 form by adding several required data elements to subsection (b)(3). For UB-04, field 51, the commenter recommends requiring submission of the HIPAA National Plan Identifier when such identifier is mandated and by otherwise requiring submission of the legacy or proprietary

number that the health plan has assigned to its particular plan operations. For UB-04, field 52, the commenter recommends requiring providers to enter an "I" to indicate informed consent to release medical information for conditions or diagnoses regulated by federal statute and when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature to be collected. The commenter further recommends that the provider enter a "Y" when the provider has a signed statement permitting the release of information related to the claim and that this submission be required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature to be collected. For UB-04, field 53, the commenter recommends requiring submission of an entry to indicate that the provider has a signed form authorizing the third party payor to remit payment directly to the provider. The commenter also notes that health plans that have arrangements with affiliate health plans in different states could use this field to make payment to the provider rather than the insured individual. Finally, for UB-04, fields 67, 67A-Q, and 72, the commenter states that the present on admission indicator should be a required submission in the eighth position of the field for certain circumstances. The commenter further indicates that the American Health Information Management Association, American Hospital Association, CMS, and the National Center for Health Statistics will publish a list of ICD-9-CM codes for which the present on admission indicator does not apply and that the submission of the present on admission indicator should be unreported only for codes on that list. The commenter indicates that the list will be

included in the present on admission guidelines published in the ICD-9-CM Official Guidelines for Coding and Reporting and updated as needed. The commenter is concerned that health plans that receive present on admission indicator information on a claim should not reject the claim because the health plan has no use for the present on admission indicator information or is not prepared to accept the fields.

Agency Response: The Department disagrees with the suggested changes. These recommendations for additional requirements related to UB-04, fields 51, 52, 53, 67, 67A – Q, and 72 would constitute substantive changes to the proposed rule. Regarding UB-04, field 51, it appears to be premature to address by rule a standard identifier that CMS has not yet implemented. Further, §21.2803(h) clarifies that the submission of data elements or information on or with a claim form by a physician or provider in addition to those required for a clean claim under the section shall not render the claim deficient. A provider is therefore not precluded from submitting additional information on a voluntary basis. The Department will monitor whether this additional information is necessary for claims processing and will consider future rulemaking as necessary. In addition, the Department will monitor progress regarding the implementation of present on admission indicators to determine the need for future rulemaking with regard to those data elements.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For: United Healthcare.

For, with changes: Texas Hospital Association and Texas Medical Association.

Against: None.

6. STATUTORY AUTHORITY. The amendments are adopted under the Insurance Code §§843.336, 1301.131, 1204.102, 1212.002, and 36.001. Sections 843.336(b) and 1301.131(a) provide that nonelectronic claims by physicians and noninstitutional providers are clean claims if the claims are submitted using form CMS-1500 or, if adopted by the Commissioner by rule, a successor to that form developed by the National Uniform Claims Committee or its successor. Sections 843.336(c) and 1301.131(b) further provide that a nonelectronic claim by an institutional provider is a clean claim if the claim is submitted using form UB-92 CMS-1450 or, if adopted by the Commissioner by rule, a successor to that form developed by the National Uniform Billing Committee (NUBC). Sections 843.336(d) and 1301.131(c) authorize the Commissioner to adopt rules that specify the information that must be entered into the appropriate fields on the applicable claim form for a claim to be a clean claim. Section 1204.102 requires a provider who seeks payment or reimbursement under a health benefit plan and the health benefit plan issuer that issued the plan to use uniform billing forms CMS-1500, UB-82 CMS-1450, or successor forms to those forms developed by the NUBC or its successor. Section 1212.002 requires the Commissioner to consult the technical advisory committee established pursuant to Chapter 1212, Insurance Code, before adopting any rule related to technical aspects of coding of health care services

and claims development, submission, processing, adjudication, and payment for medical care and health care services provided to patients. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

7. TEXT.

§21.2802. Definitions. The following words and terms when used in this subchapter shall have the following meanings:

(1) Audit--A procedure authorized and described in §21.2809 of this title (relating to Audit Procedures) under which an HMO or preferred provider carrier may investigate a claim beyond the statutory claims payment period without incurring penalties under §21.2815 of this title (relating to Failure to Meet the Statutory Claims Payment Period).

(2) Batch submission--A group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number.

(3) Billed charges--The charges for medical care or health care services included on a claim submitted by a physician or provider. For purposes of this subchapter, billed charges must comply with all other applicable requirements of law,

including Texas Health and Safety Code §311.0025, Texas Occupations Code §105.002, and Texas Insurance Code Chapter 552.

(4) CMS--The Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(5) Catastrophic event--An event, including acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, windstorm, flood or organized labor stoppages, that cannot reasonably be controlled or avoided and that causes an interruption in the claims submission or processing activities of an entity for more than two consecutive business days.

(6) Clean claim--

(A) For non-electronic claims, a claim submitted by a physician or provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured under a health insurance policy that includes:

(i) the required data elements set forth in §21.2803(b) or (c) of this title (relating to Elements of a Clean Claim); and

(ii) if applicable, the amount paid by the primary plan or other valid coverage pursuant to §21.2803(d) of this title (relating to Elements of a Clean Claim);

(B) For electronic claims, a claim submitted by a physician or provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured under a health insurance policy using the ASC X12N 837

format and in compliance with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides and trading partner agreements.

(7) Condition code--The code utilized by CMS to identify conditions that may affect processing of the claim.

(8) Contracted rate--Fee or reimbursement amount for a preferred provider's services, treatments, or supplies as established by agreement between the preferred provider and the HMO or preferred provider carrier.

(9) Corrected claim--A claim containing clarifying or additional information necessary to correct a previously submitted claim.

(10) Deficient claim--A submitted claim that does not comply with the requirements of §21.2803(b), (c) or (e) of this title.

(11) Diagnosis code--Numeric or alphanumeric codes from the International Classification of Diseases (ICD-9-CM), Diagnostic and Statistical Manual (DSM-IV), or their successors, valid at the time of service.

(12) Duplicate claim--Any claim submitted by a physician or provider for the same health care service provided to a particular individual on a particular date of service that was included in a previously submitted claim. The term does not include corrected claims, or claims submitted by a physician or provider at the request of the HMO or preferred provider carrier.

(13) HMO--A health maintenance organization as defined by Insurance Code §843.002(14).

(14) HMO delivery network--As defined by Insurance Code §843.002(15).

(15) Institutional provider--An institution providing health care services, including but not limited to hospitals, other licensed inpatient centers, ambulatory surgical centers, skilled nursing centers and residential treatment centers.

(16) NPI number--The National Provider Identifier standard unique health identifier number for health care providers assigned pursuant to 45 Code of Federal Regulations Part 162 Subpart D, or a successor rule.

(17) Occurrence span code--The code utilized by CMS to define a specific event relating to the billing period.

(18) Patient control number--A unique alphanumeric identifier assigned by the institutional provider to facilitate retrieval of individual financial records and posting of payment.

(19) Patient financial responsibility--Any portion of the contracted rate for which the patient is responsible pursuant to the terms of the patient's health benefit plan.

(20) Patient-status-at-discharge code--The code utilized by CMS to indicate the patient's status at time of discharge or billing.

(21) Physician--Anyone licensed to practice medicine in this state.

(22) Place of service code--The codes utilized by CMS that identify the place at which the service was rendered.

(23) Preferred provider--

(A) with regard to a preferred provider carrier, a preferred provider as defined by Insurance Code §1301.001 (Definitions).

(B) with regard to an HMO,

(i) a physician, as defined by Insurance Code §843.002(22), who is a member of that HMO's delivery network; or

(ii) a provider, as defined by Insurance Code §843.002(24), who is a member of that HMO's delivery network.

(24) Preferred provider carrier--An insurer that issues a preferred provider benefit plan as provided by Insurance Code Chapter 1301.

(25) Primary plan--As defined in §3.3506 of this title (relating to Use of the Terms "Plan," "Primary Plan," "Secondary Plan," and "This Plan" in Policies, Certificates and Contracts).

(26) Procedure code--Any alphanumeric code representing a service or treatment that is part of a medical code set that is adopted by CMS as required by federal statute and valid at the time of service. In the absence of an existing federal code, and for non-electronic claims only, this definition may also include local codes developed specifically by Medicaid, Medicare, an HMO, or a preferred provider carrier to describe a specific service or procedure.

(27) Provider--Any practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state, other than a physician.

(28) Revenue code--The code assigned by CMS to each cost center for which a separate charge is billed.

(29) Secondary plan--As defined in §3.3506 of this title.

(30) Source of admission code--The code utilized by CMS to indicate the source of an inpatient admission.

(31) Statutory claims payment period--

(A) the 45-calendar-day period in which an HMO or preferred provider carrier shall make claim payment or denial, in whole or in part, after receipt of a non-electronic clean claim pursuant to Insurance Code Chapters 843 and 1301;

(B) the 30-calendar-day period in which an HMO or preferred provider carrier shall make claim payment or denial, in whole or in part, after receipt of an electronically submitted clean claim pursuant to Insurance Code Chapters 843 and 1301; or

(C) the 21-calendar-day period in which an HMO or preferred provider carrier shall make claim payment after affirmative adjudication of an electronically submitted clean claim for a prescription benefit pursuant to Insurance Code Chapters 843 and 1301, and §21.2814 of this title (relating to Electronic Adjudication of Prescription Benefits).

(32) Subscriber--If individual coverage, the individual who is the contract holder and is responsible for payment of premiums to the HMO or preferred provider carrier; or if group coverage, the individual who is the certificate holder and whose employment or other membership status, except for family dependency, is the basis for eligibility for enrollment in a group health benefit plan issued by the HMO or the preferred provider carrier.

(33) Type of bill code--The three-digit alphanumeric code utilized by CMS to identify the type of facility, the type of care, and the sequence of the bill in a particular episode of care.

§21.2803. Elements of a Clean Claim.

(a) Filing a Clean Claim. A physician or provider submits a clean claim by providing to an HMO, preferred provider carrier, or any other entity designated for receipt of claims pursuant to §21.2811 of this title (related to Disclosure of Processing Procedures):

(1) for non-electronic claims, the required data elements specified in subsection (b) of this section, or for non-electronic dental claims filed with an HMO, the required data elements specified in subsection (c) of this section;

(2) for electronic claims and for electronic dental claims filed with an HMO, the required data elements specified in subsections (e) and (f) of this section; and

(3) if applicable, any coordination of benefits or non-duplication of benefits information pursuant to subsection (d) of this section.

(b) Required data elements. CMS has developed claim forms which provide much of the information needed to process claims. Insurance Code Chapter 1204 identifies two of these forms, HCFA 1500 and UB-82/HCFA, and their successor forms, as required for the submission of certain claims. The terms in paragraphs (1) – (4) of this subsection are based upon the terms CMS used on successor forms CMS-1500 (08/05), CMS-1500 (12/90), UB-04 CMS-1450, and UB-92 CMS-1450. The parenthetical information following each term refers to the applicable CMS claim form and the field number to which that term corresponds on the CMS claim form. Mandatory form usage dates and optional form transition dates for nonelectronic claims filed or re-filed by physicians or noninstitutional providers are set forth in paragraphs (1) and (2) of this subsection. Mandatory form usage dates and optional form transition dates for nonelectronic claims filed or re-filed by institutional providers are set forth in paragraphs (3) and (4) of this subsection.

(1) Required form and data elements for physicians or noninstitutional providers for claims filed or re-filed on or after the later of July 18, 2007, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (08/05) for Medicare claims. The CMS-1500 (08/05) and the data elements described in this paragraph are required for claims filed or re-filed by physicians or noninstitutional providers on or after the later of these two dates: July 18, 2007, or the earliest

compliance date required by CMS for mandatory use of the CMS-1500 (08/05) for Medicare claims. The CMS-1500 (08/05) must be completed in accordance with the special instructions applicable to the data element as described by this paragraph for clean claims filed by physicians and noninstitutional providers. Further, upon notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on form CMS-1500 (08/05), a physician or noninstitutional provider may submit claims on form CMS-1500 (08/05) prior to the mandatory use date described in this paragraph, subject to the required data elements set forth in this paragraph.

(A) subscriber's/patient's plan ID number (CMS-1500 (08/05), field 1a) is required;

(B) patient's name (CMS-1500 (08/05), field 2) is required;

(C) patient's date of birth and gender (CMS-1500 (08/05), field 3) is required;

(D) subscriber's name (CMS-1500 (08/05), field 4) is required, if shown on the patient's ID card;

(E) patient's address (street or P.O. Box, city, state, ZIP) (CMS-1500 (08/05), field 5) is required;

(F) patient's relationship to subscriber (CMS-1500 (08/05), field 6) is required;

(G) subscriber's address (street or P.O. Box, city, state, ZIP) (CMS-1500 (08/05), field 7) is required, but physician or provider may enter "same" if

the subscriber's address is the same as the patient's address required by subparagraph (E) of this paragraph;

(H) other insured's or enrollee's name (CMS-1500 (08/05), field 9) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (1)(Q) of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

(I) other insured's or enrollee's policy/group number (CMS-1500 (08/05), field 9a) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (1)(Q) of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

(J) other insured's or enrollee's date of birth (CMS-1500 (08/05), field 9b) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data

element specified in paragraph (1)(Q) of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

(K) other insured's or enrollee's plan name (employer, school, etc.) (CMS-1500 (08/05), field 9c) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (1)(Q) of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element. If the field is required and the physician or provider is a facility-based radiologist, pathologist, or anesthesiologist with no direct patient contact, the physician or provider must either enter the information or enter "NA" (not available) if the information is unknown;

(L) other insured's or enrollee's HMO or insurer name (CMS-1500 (08/05), field 9d) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (1)(Q) of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or

provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

(M) whether patient's condition is related to employment, auto accident, or other accident (CMS-1500 (08/05), field 10) is required, but facility-based radiologists, pathologists, or anesthesiologists shall enter "N" if the answer is "No" or if the information is not available;

(N) if the claim is a duplicate claim, a "D" is required; if the claim is a corrected claim, a "C" is required (CMS-1500 (08/05), field 10d);

(O) subscriber's policy number (CMS-1500 (08/05), field 11) is required;

(P) HMO or insurance company name (CMS-1500 (08/05), field 11c) is required;

(Q) disclosure of any other health benefit plans (CMS-1500 (08/05), field 11d) is required;

(i) if answered "yes," then:

(I) data elements specified in paragraph (1)(H) - (L) of this subsection are required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete the data elements in paragraph (1)(H) - (L) of this subsection;

(II) the data element specified in paragraph (1)(II) of this subsection is required when submitting claims to secondary payor HMOs or preferred provider carriers;

(ii) if answered "no," the data elements specified in paragraph (1)(H) - (L) of this subsection are not required if the physician or provider has on file a document signed within the past 12 months by the patient or authorized person stating that there is no other health care coverage; although the submission of the signed document is not a required data element, the physician or provider shall submit a copy of the signed document to the HMO or preferred provider carrier upon request;

(R) patient's or authorized person's signature or notation that the signature is on file with the physician or provider (CMS-1500 (08/05), field 12) is required;

(S) subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider (CMS-1500 (08/05), field 13) is required;

(T) date of injury (CMS-1500 (08/05), field 14) is required if due to an accident;

(U) when applicable, the physician or provider shall enter the name of the referring primary care physician, specialty physician, hospital, or other source (CMS-1500 (08/05), field 17); however, if there is no referral, the physician or provider shall enter "Self-referral" or "None";

(V) if there is a referring physician noted in CMS-1500 (08/05), field 17, the physician or provider shall enter the ID Number of the referring primary care physician, specialty physician, or hospital (CMS-1500 (08/05), field 17a);

(W) for claims filed or re-filed on or after May 23, 2008, if there is a referring physician noted in CMS-1500 (08/05), field 17, the physician or provider shall enter the NPI number of the referring primary care physician, specialty physician, or hospital (CMS-1500 (08/05), field 17b) if the referring physician is eligible for an NPI number;

(X) narrative description of procedure (CMS-1500 (08/05), field 19) is required when a physician or provider uses an unlisted or not classified procedure code or an NDC code for drugs;

(Y) for diagnosis codes or nature of illness or injury (CMS-1500 (08/05), field 21), up to four diagnosis codes may be entered, but at least one is required (primary diagnosis must be entered first);

(Z) verification number (CMS-1500 (08/05), field 23) is required if services have been verified pursuant to §19.1724 of this title (relating to Verification). If no verification has been provided, a prior authorization number (CMS 1500 (08/05), field 23) is required when prior authorization is required and granted;

(AA) date(s) of service (CMS-1500 (08/05), field 24A) is required;

(BB) place of service code(s) (CMS-1500 (08/05), field 24B) is required;

(CC) procedure/modifier code (CMS-1500 (08/05), field 24D) is required;

(DD) diagnosis code by specific service (CMS-1500 (08/05), field 24E) is required with the first code linked to the applicable diagnosis code for that service in field 21;

(EE) charge for each listed service (CMS-1500 (08/05), field 24F) is required;

(FF) number of days or units (CMS-1500 (08/05), field 24G) is required;

(GG) for claims filed or re-filed on or after May 23, 2008, the NPI number of the rendering physician or provider (CMS-1500 (08/05), field 24J, unshaded portion) is required if the rendering provider is not the billing provider listed in CMS-1500 (08/05), field 33, and if the rendering physician or provider is eligible for an NPI number;

(HH) physician's or provider's federal tax ID number (CMS-1500 (08/05), field 25) is required;

(II) whether assignment was accepted (CMS-1500 (08/05), field 27) is required if assignment under Medicare has been accepted;

(JJ) total charge (CMS-1500 (08/05), field 28) is required;

(KK) amount paid (CMS-1500 (08/05), field 29) is required if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber or by a primary plan in accordance

with paragraph (1)(P) of this subsection and as required by subsection (d) of this section;

(LL) signature of physician or provider or notation that the signature is on file with the HMO or preferred provider carrier (CMS-1500 (08/05), field 31) is required;

(MM) name and address of facility where services rendered (if other than home) (CMS-1500 (08/05), field 32) is required;

(NN) for claims filed or re-filed on or after May 23, 2008, the NPI number of facility where services are rendered (other than home) is required (CMS-1500 (08/05), field 32a) if the facility is eligible for an NPI;

(OO) physician's or provider's billing name, address and telephone number (CMS-1500 (08/05), field 33) is required;

(PP) for claims filed or re-filed on or after May 23, 2008, the NPI number of billing provider (CMS-1500 (08/05), field 33a) is required if the billing provider is eligible for an NPI number; and

(QQ) provider number (CMS-1500 (08/05), field 33b) is required if the HMO or preferred provider carrier required provider numbers and gave notice of the requirement to physicians and providers prior to June 17, 2003.

(2) Required form and data elements for physicians or noninstitutional providers for claims filed or re-filed before the later of July 18, 2007, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (08/05) for

Medicare claims. The CMS-1500 (12/90) and the data elements described in this paragraph are required for claims filed or re-filed by physicians or noninstitutional providers before the later of these two dates: July 18, 2007, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (08/05) for Medicare claims. The CMS-1500 (12/90) must be completed in accordance with the special instructions applicable to the data element as described in this paragraph for clean claims filed by physicians and noninstitutional providers. However, upon notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on form CMS-1500 (08/05), a physician or noninstitutional provider may submit claims on form CMS-1500 (08/05) prior to the subsection (b)(1) mandatory use date, subject to the subsection (b)(1) required data elements.

(A) subscriber's/patient's plan ID number (CMS-1500 (12/90), field 1a) is required;

(B) patient's name (CMS-1500 (12/90), field 2) is required;

(C) patient's date of birth and gender (CMS-1500 (12/90), field 3) is required;

(D) subscriber's name (CMS-1500 (12/90), field 4) is required, if shown on the patient's ID card;

(E) patient's address (street or P.O. Box, city, state, ZIP) (CMS-1500 (12/90), field 5) is required;

(F) patient's relationship to subscriber (CMS-1500 (12/90), field 6) is required;

(G) subscriber's address (street or P.O. Box, city, state, ZIP) (CMS-1500 (12/90), field 7) is required, but physician or provider may enter "same" if the subscriber's address is the same as the patient's address required by subparagraph (E) of this paragraph;

(H) other insured's or enrollee's name (CMS-1500 (12/90), field 9) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (2)(Q) of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

(I) other insured's or enrollee's policy/group number (CMS-1500 (12/90), field 9a) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (2)(Q) of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has

made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

(J) other insured's or enrollee's date of birth (CMS-1500 (12/90), field 9b) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (2)(Q) of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

(K) other insured's or enrollee's plan name (employer, school, etc.) (CMS-1500 (12/90), field 9c) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (2)(Q) of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element. If the field is required and the physician or provider is a facility-based radiologist, pathologist or anesthesiologist with no direct patient contact, the physician or provider must either enter the information or enter "NA" (not available) if the information is unknown;

(L) other insured's or enrollee's HMO or insurer name (CMS-1500 (12/90), field 9d) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required data element specified in paragraph (2)(Q) of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

(M) whether patient's condition is related to employment, auto accident, or other accident (CMS-1500 (12/90, field 10) is required, but facility-based radiologists, pathologists, or anesthesiologists shall enter "N" if the answer is "No" or if the information is not available;

(N) if the claim is a duplicate claim, a "D" is required; if the claim is a corrected claim, a "C" is required (CMS-1500 (12/90), field 10d);

(O) subscriber's policy number (CMS-1500 (12/90), field 11) is required;

(P) HMO or insurance company name (CMS-1500 (12/90), field 11c) is required;

(Q) disclosure of any other health benefit plans (CMS-1500 (12/90), field 11d) is required;

(i) if answered "yes", then:

(I) data elements specified in paragraph (2)(H) – (L) of this subsection are required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete the data elements in paragraph (2)(H) – (L) of this subsection;

(II) the data element specified in paragraph (2)(II) of this subsection is required when submitting claims to secondary payor HMOs or preferred provider carriers;

(ii) if answered "no", the data elements specified in paragraph (2)(H) – (L) of this subsection are not required if the physician or provider has on file a document signed within the past 12 months by the patient or authorized person stating that there is no other health care coverage; although the submission of the signed document is not a required data element, the physician or provider shall submit a copy of the signed document to the HMO or preferred provider carrier upon request;

(R) patient's or authorized person's signature or notation that the signature is on file with the physician or provider (CMS-1500 (12/90), field 12) is required;

(S) subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider (CMS-1500 (12/90), field 13) is required;

(T) date of injury (CMS-1500 (12/90), field 14) is required, if due to an accident;

(U) when applicable, the physician or provider shall enter the name of the referring primary care physician, specialty physician, hospital, or other source (CMS-1500 (12/90) field 17); however, if there is no referral, the physician or provider shall enter "Self-referral" or "None";

(V) the physician or provider shall enter the ID Number of the referring primary care physician, specialty physician, or hospital (CMS-1500 (12/90), field 17a); however, if there is no referral, the physician or provider shall enter "Self-referral" or "None";

(W) narrative description of procedure (CMS-1500 (12/90), field 19) is required when a physician or provider uses an unlisted or not classified procedure code or an NDC code for drugs;

(X) for diagnosis codes or nature of illness or injury (CMS-1500 (12/90), field 21), up to four diagnosis codes may be entered, but at least one is required (primary diagnosis must be entered first);

(Y) verification number (CMS-1500 (12/90), field 23) is required if services have been verified pursuant to §19.1724 of this title (relating to Verification). If no verification has been provided, a prior authorization number (CMS-1500 (12/90), field 23) is required when prior authorization is required and granted;

(Z) date(s) of service (CMS-1500 (12/90), field 24A) is required;

(AA) place of service code(s) (CMS-1500 (12/90), field 24B) is required;

(BB) procedure/modifier code (CMS-1500 (12/90), field 24D) is required;

(CC) diagnosis code by specific service (CMS-1500 (12/90), field 24E) is required with the first code linked to the applicable diagnosis code for that service in field 21;

(DD) charge for each listed service (CMS-1500 (12/90), field 24F) is required;

(EE) number of days or units (CMS-1500 (12/90), field 24G) is required;

(FF) physician's or provider's federal tax ID number (CMS-1500 (12/90), field 25) is required;

(GG) whether assignment was accepted (CMS-1500 (12/90), field 27) is required if assignment under Medicare has been accepted;

(HH) total charge (CMS-1500 (12/90), field 28) is required;

(II) amount paid (CMS-1500 (12/90), field 29) is required if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber or by a primary plan in accordance with paragraph (2)(P) of this subsection and as required by subsection (d) of this section;

(JJ) signature of physician or provider or notation that the signature is on file with the HMO or preferred provider carrier (CMS-1500 (12/90), field 31) is required;

(KK) name and address of facility where services rendered (if other than home or office) (CMS-1500 (12/90), field 32) is required; and

(LL) physician's or provider's billing name, address, and telephone number is required, and the provider number (CMS-1500 (12/90), field 33) is required if the HMO or preferred provider carrier required provider numbers and gave notice of that requirement to physicians and providers prior to June 17, 2003.

(3) Required form and data elements for institutional providers for claims filed or re-filed on or after July 18, 2007. The UB-04 CMS-1450 and the data elements described in this paragraph are required for claims filed or re-filed by institutional providers on or after July 18, 2007. The UB-04 CMS-1450 must be completed in accordance with the special instructions applicable to the data elements as described by this paragraph for clean claims filed by institutional providers. Further, upon notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on form UB-04 CMS-1450, an institutional provider may submit claims on UB-04 CMS-1450 prior to the mandatory use date described in this paragraph, subject to the required data elements set forth in this paragraph.

(A) provider's name, address, and telephone number (UB-04, field 1) is required;

(B) patient control number (UB-04, field 3a) is required;

(C) type of bill code (UB-04, field 4) is required and shall include a "7" in the fourth position if the claim is a corrected claim;

(D) provider's federal tax ID number (UB-04, field 5) is required;

(E) statement period (beginning and ending date of claim period) (UB-04, field 6) is required;

(F) patient's name (UB-04, field 8a) is required;

(G) patient's address (UB-04, field 9a - 9e) is required;

(H) patient's date of birth (UB-04, field 10) is required;

(I) patient's gender (UB-04, field 11) is required;

(J) date of admission (UB-04, field 12) is required for admissions, observation stays, and emergency room care;

(K) admission hour (UB-04, field 13) is required for admissions, observation stays, and emergency room care;

(L) type of admission (e.g., emergency, urgent, elective, newborn) (UB-04, field 14) is required for admissions;

(M) source of admission code (UB-04, field 15) is required;

(N) discharge hour (UB-04, field 16) is required for admissions, outpatient surgeries, or observation stays;

(O) patient-status-at-discharge code (UB-04, field 17) is required for admissions, observation stays, and emergency room care;

(P) condition codes (UB-04, fields 18 - 28) are required if the CMS UB-04 manual contains a condition code appropriate to the patient's condition;

(Q) occurrence codes and dates (UB-04, fields 31 - 34) are required if the CMS UB-04 manual contains an occurrence code appropriate to the patient's condition;

(R) occurrence span codes and from and through dates (UB-04, fields 35 and 36) are required if the CMS UB-04 manual contains an occurrence span code appropriate to the patient's condition;

(S) value code and amounts (UB-04, fields 39 - 41) are required for inpatient admissions. If no value codes are applicable to the inpatient admission, the provider may enter value code 01;

(T) revenue code (UB-04, field 42) is required;

(U) revenue description (UB-04, field 43) is required;

(V) HCPCS/Rates (UB-04, field 44) are required if Medicare is a primary or secondary payor;

(W) service date (UB-04, field 45) is required if the claim is for outpatient services;

(X) date bill submitted (UB-04, field 45, line 23) is required;

(Y) units of service (UB-04, field 46) are required;

(Z) total charge (UB-04, field 47) is required;

(AA) HMO or preferred provider carrier name (UB-04, field 50) is required;

(BB) prior payments-payor (UB-04, field 54) are required if payments have been made to the physician or provider by a primary plan as required by subsection (d) of this section;

(CC) for claims filed or re-filed on or after May 23, 2008, the NPI number of the billing provider (UB-04, field 56) is required if the billing provider is eligible for an NPI number;

(DD) other provider number (UB-04, field 57) is required if the HMO or preferred provider carrier, prior to June 17, 2003, required provider numbers and gave notice of that requirement to physicians and providers;

(EE) subscriber's name (UB-04, field 58) is required if shown on the patient's ID card;

(FF) patient's relationship to subscriber (UB-04, field 59) is required;

(GG) patient's/subscriber's certificate number, health claim number, ID number (UB-04, field 60) is required if shown on the patient's ID card;

(HH) insurance group number (UB-04, field 62) is required if a group number is shown on the patient's ID card;

(II) verification number (UB-04, field 63) is required if services have been verified pursuant to §19.1724 of this title. If no verification has been provided,

treatment authorization codes (UB-04, field 63) are required when authorization is required and granted;

(JJ) principal diagnosis code (UB-04, field 67) is required;

(KK) diagnoses codes other than principal diagnosis code (UB-04, fields 67A - 67Q) are required if there are diagnoses other than the principal diagnosis;

(LL) admitting diagnosis code (UB-04, field 69) is required;

(MM) principal procedure code (UB-04, field 74) is required if the patient has undergone an inpatient or outpatient surgical procedure;

(NN) other procedure codes (UB-04, fields 74 - 74e) are required as an extension of subparagraph (MM) of this paragraph if additional surgical procedures were performed;

(OO) attending physician NPI number (UB-04, field 76) is required on or after May 23, 2008, if attending physician is eligible for an NPI number; and

(PP) attending physician ID (UB-04, field 76, qualifier portion) is required.

(4) Required form and data elements for institutional providers for claims filed or re-filed before July 18, 2007. The UB-92 CMS-1450 and the data elements described in this paragraph are required for claims filed or re-filed by institutional providers before July 18, 2007. The UB-92 CMS-1450 must be completed in accordance with the special instructions applicable to the data element as described in this paragraph for clean claims filed by institutional providers. However, upon

notification that an HMO or preferred provider carrier will accept claims filed or re-filed on form UB-04 CMS-1450, an institutional provider may submit claims on form UB-04 CMS-1450 prior to the subsection (b)(3) mandatory use date, subject to the subsection (b)(3) required data elements.

(A) provider's name, address and telephone number (UB-92, field 1) is required;

(B) patient control number (UB-92, field 3) is required;

(C) type of bill code (UB-92, field 4) is required and shall include a "7" in the third position if the claim is a corrected claim;

(D) provider's federal tax ID number (UB-92, field 5) is required;

(E) statement period (beginning and ending date of claim period) (UB-92, field 6) is required;

(F) covered days (UB-92, field 7) is required if Medicare is a primary or secondary payor;

(G) noncovered days (UB-92, field 8) is required if Medicare is a primary or secondary payor;

(H) coinsurance days (UB-92, field 9) is required if Medicare is a primary or secondary payor;

(I) lifetime reserve days (UB-92, field 10) is required if Medicare is a primary or secondary payor and the patient was an inpatient;

(J) patient's name (UB-92, field 12) is required;

(K) patient's address (UB-92, field 13) is required;

(L) patient's date of birth (UB-92, field 14) is required;

(M) patient's gender (UB-92, field 15) is required;

(N) patient's marital status (UB-92, field 16) is required;

(O) date of admission (UB-92, field 17) is required for admissions, observation stays, and emergency room care;

(P) admission hour (UB-92, field 18) is required for admissions, observation stays, and emergency room care;

(Q) type of admission (e.g., emergency, urgent, elective, newborn) (UB-92, field 19) is required for admissions;

(R) source of admission code (UB-92, field 20) is required;

(S) discharge hour (UB-92, field 21) is required for admissions, outpatient surgeries, or observation stays;

(T) patient-status-at-discharge code (UB-92, field 22) is required for admissions, observation stays, and emergency room care;

(U) condition codes (UB-92, fields 24 - 30) are required if the CMS UB-92 manual contains a condition code appropriate to the patient's condition;

(V) occurrence codes and dates (UB-92, fields 32 - 35) are required if the CMS UB-92 manual contains an occurrence code appropriate to the patient's condition;

(W) occurrence span code, from and through dates (UB-92, field 36), are required if the CMS UB-92 manual contains an occurrence span code appropriate to the patient's condition;

(X) value code and amounts (UB-92, fields 39-41) are required for inpatient admissions. If no value codes are applicable to the inpatient admission, the provider may enter value code 01;

(Y) revenue code (UB-92, field 42) is required;

(Z) revenue description (UB-92, field 43) is required;

(AA) HCPCS/Rates (UB-92, field 44) are required if Medicare is a primary or secondary payor;

(BB) Service date (UB-92, field 45) is required if the claim is for outpatient services;

(CC) units of service (UB-92, field 46) are required;

(DD) total charge (UB-92, field 47) is required;

(EE) HMO or preferred provider carrier name (UB-92, field 50) is required;

(FF) provider number (UB-92, field 51) is required if the HMO or preferred provider carrier, prior to June 17, 2003, required provider numbers and gave notice of that requirement to physicians and providers.

(GG) prior payments-payor and patient (UB-92, field 54) are required if payments have been made to the physician or provider by the patient or

another payor or subscriber, on behalf of the patient or subscriber, or by a primary plan as required by subsection (d) of this section;

(HH) subscriber's name (UB-92, field 58) is required if shown on the patient's ID card;

(II) patient's relationship to subscriber (UB-92, field 59) is required;

(JJ) patient's/subscriber's certificate number, health claim number, ID number (UB-92, field 60) is required if shown on the patient's ID card;

(KK) insurance group number (UB-92, field 62) is required if a group number is shown on the patient's ID card;

(LL) verification number (UB-92, field 63) is required if services have been verified pursuant to §19.1724 of this title. If no verification has been provided, treatment authorization codes (UB-92, field 63) are required when authorization is required and granted;

(MM) principal diagnosis code (UB-92, field 67) is required;

(NN) diagnoses codes other than principal diagnosis code (UB-92, fields 68 - 75) are required if there are diagnoses other than the principal diagnosis;

(OO) admitting diagnosis code (UB-92, field 76) is required;

(PP) procedure coding methods used (UB-92, field 79) is required if the CMS UB-92 manual indicates a procedural coding method appropriate to the patient's condition;

(QQ) principal procedure code (UB-92, field 80) is required if the patient has undergone an inpatient or outpatient surgical procedure;

(RR) other procedure codes (UB-92, field 81) are required as an extension of subparagraph (QQ) of this paragraph if additional surgical procedures were performed;

(SS) attending physician ID (UB-92, field 82) is required;

(TT) signature of provider representative, electronic signature or notation that the signature is on file with the HMO or preferred provider carrier (UB-92, field 85) is required; and

(UU) date bill submitted (UB-92, field 86) is required.

(c) Required data elements-dental claims. The data elements described in this subsection are required as indicated and must be completed or provided in accordance with the special instructions applicable to the data elements for non-electronic clean claims filed by dental providers with HMOs.

(1) Patient's name is required;

(2) Patient's address is required;

(3) Patient's date of birth is required;

(4) Patient's gender is required;

(5) Patient's relationship to subscriber is required;

(6) Subscriber's name is required;

(7) Subscriber's address is required, but provider may enter "same" if the subscriber's address is the same as the patient's address required by paragraph (2) of this subsection;

(8) Subscriber's date of birth is required, if shown on the patient's ID card;

(9) Subscriber's gender is required;

(10) Subscriber's identification number is required, if shown on the patient's ID card;

(11) Subscriber's plan/group number is required, if shown on the patient's ID card;

(12) HMO's name is required;

(13) HMO's address is required;

(14) Disclosure of any other plan providing dental benefits is required and shall include a "no" if the patient is not covered by another plan providing dental benefits. If the patient does have other coverage, the provider shall indicate "yes" and the elements in paragraphs (15) - (20) of this subsection are required unless the provider submits with the claim documented proof to the HMO that the provider has made a good faith but unsuccessful attempt to obtain from the enrollee any of the information needed to complete the data elements;

(15) Other insured's or enrollee's name is required in accordance with the response to and requirements of paragraph (14) of this subsection;

(16) Other insured's or enrollee's date of birth is required in accordance with the response to and requirements of the element in paragraph (15) of this subsection;

(17) Other insured's or enrollee's gender is required in accordance with the response to and requirements of the element in paragraph (15) of this subsection;

(18) Other insured's or enrollee's identification number is required in accordance with the response to and requirements of the element in paragraph (15) of this subsection;

(19) Patient's relationship to other insured or enrollee is required in accordance with the response to and requirements of the element in paragraph (15) of this subsection;

(20) Name of other HMO or insurer is required in accordance with the response to and requirements of the element in paragraph (15) of this subsection;

(21) Verification or preauthorization number is required, if a verification or preauthorization number was issued by an HMO to the provider;

(22) Date(s) of service(s) or procedure(s) is required;

(23) Area of oral cavity is required, if applicable;

(24) Tooth system is required, if applicable;

(25) Tooth number(s) or letter(s) are required, if applicable;

(26) Tooth surface is required, if applicable;

(27) Procedure code for each service is required;

(28) Description of procedure for each service is required, if applicable;

(29) Charge for each listed service is required;

(30) Total charge for the claim is required;

(31) Missing teeth information is required, if a prosthesis constitutes part of the claim. A provider that provides information for this element shall include the tooth number(s) or letter(s) of the missing teeth;

(32) Notification of whether the services were for orthodontic treatment is required. If the services were for orthodontic treatment, the elements in paragraphs (34) and (35) of this subsection are required;

(33) Date of orthodontic appliance placement is required, if applicable;

(34) Months of orthodontic treatment remaining is required, if applicable;

(35) Notification of placement of prosthesis is required, if applicable. If the services included placement of a prosthesis, the element in paragraph (36) of this subsection is required;

(36) Date of prior prosthesis placement is required, if applicable;

(37) Name of billing provider is required;

(38) Address of billing provider is required;

(39) Billing provider's provider identification number is required, if applicable;

(40) Billing provider's license number is required;

(41) Billing provider's social security number or federal tax identification number is required;

(42) Billing provider's telephone number is required; and

(43) Treating provider's name and license number are required if the treating provider is not the billing provider.

(d) Coordination of benefits or non-duplication of benefits. If a claim is submitted for covered services or benefits in which coordination of benefits pursuant to §§3.3501 - 3.3511 of this title (relating to Group Coordination of Benefits) and §11.511(1) of this title (relating to Optional Provisions) is necessary, the amount paid as a covered claim by the primary plan is a required element of a clean claim for purposes of the secondary plan's processing of the claim and CMS-1500 (08/05), field 29; CMS-1500 (12/90), field 29; UB-04, field 54; or UB-92, field 54, as applicable, must be completed pursuant to subsection (b)(1)(KK), (2)(II), (3)(BB), and (4)(GG) of this section. If a claim is submitted for covered services or benefits in which non-duplication of benefits pursuant to §3.3053 of this title (relating to Non-duplication of Benefits Provision) is an issue, the amounts paid as a covered claim by all other valid coverage is a required element of a clean claim and CMS-1500 (08/05), field 29; CMS-1500 (12/90), field 29; UB-04, field 54; or UB-92, field 54, as applicable, must be completed pursuant to subsection (b)(1)(KK), (2)(II), (3)(BB), and (4)(GG) of this section. If a claim is submitted for covered services or benefits and the policy contains a variable deductible provision as set forth in §3.3074(a)(4) of this title (relating to Minimum Standards for Major Medical

Expense Coverage), the amount paid as a covered claim by all other health insurance coverages, except for amounts paid by individually underwritten and issued hospital confinement indemnity, specified disease, or limited benefit plans of coverage, is a required element of a clean claim and CMS-1500 (08/05), field 29; CMS-1500 (12/90), field 29; UB-04, field 54; or UB-92, field 54, as applicable, must be completed pursuant to subsection (b)(1)(KK), (2)(II), (3)(BB), and (4)(GG) of this section. Notwithstanding these requirements, an HMO or preferred provider carrier may not require a physician or provider to investigate coordination of other health benefit plan coverage.

(e) A physician or provider submits an electronic clean claim by submitting a claim using the applicable format that complies with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides and trading partner agreements.

(f) If a physician or provider submits an electronic clean claim that requires coordination of benefits pursuant to §§3.3501 - 3.3511 of this title (relating to Group Coordination of Benefits) or §11.511(1) of this title (relating to Optional Provisions), the HMO or preferred provider carrier processing the claim as a secondary payor shall rely on the primary payor information submitted on the claim by the physician or provider. The primary payor may submit primary payor information electronically to the secondary payor using the ASC X12N 837 format and in compliance with federal laws related to electronic health care claims, including applicable implementation guides, companion guides and trading partner agreements.

(g) Format of elements. The elements of a clean claim set forth in subsections (b), (c), (d), (e) and (f), if applicable, of this section must be complete, legible and accurate.

(h) Additional data elements or information. The submission of data elements or information on or with a claim form by a physician or provider in addition to those required for a clean claim under this section shall not render such claim deficient.

CERTIFICATION. This agency hereby certifies that the adopted amendments have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2007.

_____
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that the amendments to §21.2802 and §21.2803 specified herein, concerning elements of a clean health care claim, are adopted.

AND IT IS SO ORDERED.

_____
MIKE GEESLIN
COMMISSIONER OF INSURANCE

ATTEST:

_____
Gene C. Jarmon
General Counsel and Chief Clerk

COMMISSIONER'S ORDER NO._____