SUBCHAPTER T. Submission of Clean Claims

28 TAC §§21.2801 – 21.2809 and §§21.2811 – 21.2826

1. INTRODUCTION. The Texas Department of Insurance adopts amendments to 28 TAC §§21.2801 – 21.2809 and §§21.2811 – 21.2826, concerning the elements and the processing of a clean health care claim. The amendments are adopted with changes to the proposed text published in the November 15, 2013, issue of the *Texas Register* (38 TexReg 8105).

2. REASONED JUSTIFICATION. The National Uniform Claims Committee (NUCC), the National Uniform Billing Committee (NUBC), and the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) have identified much of the information needed to process a health care claim. Texas Insurance Code §1204.102 requires a provider to use one of two forms, the HCFA 1500 or UB-82/HCFA, or their successor forms, for submission of certain claims. The amendments are needed to allow a physician or other provider to begin using CMS-1500 (02/12), the most current successor form to the HCFA 1500; to begin phasing out successor form CMS-1500 (08/05); and to eliminate forms CMS-1500 (12/90) and UB-92 CMS-1450, which are no longer used. The amendments also reflect changes to data elements captured in the revised information fields in the newest successor form.

House Bill 1772, 82nd Legislature, Regular Session (2011), amended Insurance Code §1301.0041 to add exclusive provider benefit plans to the entities regulated by the chapter. Under 28 TAC §3.3701, a provision that applies to a preferred provider

benefit plan also applies to an exclusive provider benefit plan. The rule amendments clarify that these rules apply to an exclusive provider benefit plan carrier unless specifically excepted. For this reason, the term “managed care carrier” (MCC) is substituted for the phrase "HMO or preferred provider carrier" throughout the rule to more easily identify the three types of entities regulated by Subchapter T.

House Bill 2292, 82nd Legislature, Regular Session (2011), amended Insurance Code §843.339 and §1301.104 to provide that a pharmacy claim submitted electronically to a managed care carrier must be paid by electronic funds transfer not later than 18 days after its affirmative adjudication, and a pharmacy claim submitted nonelectronically must be paid not later than 21 days after its affirmative adjudication. The amendments are needed to incorporate those timelines into these rules.

House Bill 2064, 81st Legislature, Regular Session (2009), amended Insurance Code §843.342 and §1301.137 to provide that a portion of certain penalty payments and interest payments that are statutorily paid by managed care carriers for late payment and underpayment of clean claims would be paid to the Texas Health Insurance Pool (Pool). The amendments are needed to incorporate those payments into the rule.

Senate Bill 1367, 83rd Legislature, Regular Session (2013) abolishes the Pool and reallocates payments made to the Pool under the clean claims rules to the department on the Pool’s dissolution. The amendments are needed to add that reallocation to the rule.

Throughout the rule nonsubstantive amendments are made to conform the subchapter to the current codification and language of the Insurance and Administrative Codes, to update the rule's internal references, and to make minor language, punctuation, and grammatical changes to conform to the department's style guidelines and make the rules easier to read, understand, and use. These nonsubstantive amendments will be noted in the explanatory text below, but will not be described in detail.

The rule as adopted includes nonsubstantive changes to several of the proposed provisions. The changes do not materially alter issues raised in the proposal, introduce new subject matter, or add costs or requirements to persons other than those previously on notice. Specifically:

- The adopted definition of "MCC or managed care carrier" does not include the phrase "except as prohibited by federal law." §21.2802(17).
- The adopted definition of "preferred provider carrier" does not include the sentence, "The term does not include an insurer that issues an exclusive provider benefit plan." §21.2802(27).
- The department has changed the rule's clause about CMS' transition from the ICD-9-CM to the ICD-10-CM to make clearer how to complete CMS-1500 (02/12) data field 21 throughout that transition. §21.2803(b)(1)(U)(i).
- The department has changed the CMS-1500 (02/12) data field used to indicate a duplicate or corrected claim from field 30 to field 22, moved the provision from

subparagraph §21.2803(b)(1)(HH) to (V), and renumbered the intervening subparagraphs.

3. HOW THE SECTIONS WILL FUNCTION. Adopted amendments to §21.2801 (Purpose and Scope) reflect the recodification of repealed Insurance Code Article 3.70-3C as Chapter 1301 and add exclusive provider carriers to the entities governed by the rules, but exclude from the rule's coverage an exclusive provider benefit plan regulated under Chapter 3, Subchapter KK (Exclusive Provider Benefit Plan) of this title, which provides services under the Texas Children's Health Insurance Program or with the Statewide Rural Healthcare Program.

Adopted amendments to §21.2802 (Definitions) add a definition of "exclusive provider carrier" because Insurance Code Chapter 1301 and these rules now apply to exclusive provider plans as set out in Insurance Code §1301.0041 and §1301.0042. The amendments add a definition of "managed care carrier" (MCC) to be substituted for the phrase "HMO or preferred provider carrier" throughout the balance of the rule to more easily identify the three types of entities now governed by this subchapter (HMO, preferred provider carrier, and exclusive provider carrier). §21.2802 (13) and (17). The definition for *source of admission code* has been renamed *Point of Origin for Admission or Visit*, and relocated to conform with the language of the new CMS-1500 (02/12) form. §21.2802(25). The definition of *preferred provider* is amended to reflect that the term includes providers in both preferred provider plans and exclusive provider plans. §21.2802(26). The definitions of *primary plan* and *secondary plan* are amended in anticipation of a successor rule to existing 28 TAC Chapter 3, Subchapter V, §§3.3501

− 3.3511 (Group Coordination of Benefits). §21.2802(28) and (32). The definition of *statutory claims payment period* is amended to include the extended payment periods permitted under §21.2804 (Requests for Additional Information from Treating Preferred Provider) and §21.2819 (Catastrophic Event), and to add the payment periods that apply to electronically and nonelectronically submitted claims for prescription benefits. §21.2802(33).

Several subsections of §21.2803 (Elements of a Clean Claim) have been amended. Adopted amendments to §21.2803(a) (Filing a Clean Claim) make it easier to locate the requirements for submission of nonelectronic dental claims, and electronic claims (including electronic dental claims submitted to an HMO).

Adopted amendments to §21.2803(b) (Required Data Elements) require the use of a successor form for physicians or noninstitutional providers using the CMS-1500 claim form and delete the now-obsolete CMS-1500 (12/90). Also deleted is the UB-92, a now-obsolete version of the UB claim form used by institutional providers. The amendments establish optional timelines to allow for transition to the new forms, establish mandatory use dates, and set out the data elements a physician or provider must use to submit a clean claim on the new successor form CMS-1500 (02/12).

Adopted amendments to §21.2803(b)(1) redesignate former subsection (b)(1) as subsection (b)(2) and add a new subsection (b)(1). New §21.2803(b)(1) requires a physician or noninstitutional provider to use the CMS-1500 (02/12) form for nonelectronic claims filed or refiled on or after April 1, 2014, or the earliest compliance date established by CMS for mandatory use of the CMS-1500 (02/12) form for

Medicare claims. New §21.2803(b)(1) also establishes an optional transition period before the new form's mandatory use date. During the transition period, when an MCC notifies a physician or noninstitutional provider that it is prepared to accept claims filed or refiled on the new form before its mandatory use date, the physician or noninstitutional provider may submit claims using this successor form using the appropriate data elements. New §21.2803(b)(1) lists the data elements that a physician or noninstitutional provider must complete to submit a clean claim on the CMS-1500 (02/12). New §21.2803(b)(1)(A) – (NN) specifies the field location of those data elements.

Adopted amendments to §21.2803(b)(2) delete the text of existing paragraph §21.2803(b)(2) to eliminate all references to obsolete form CMS-1500 (12/90). The amendments also redesignate existing paragraph §21.2803(b)(1) as §21.2803(b)(2) to address the phase-out period for form CMS-1500 (08/05). The amended paragraph specifies that a physician or noninstitutional provider filing or refiling a nonelectronic claim before the later of April 1, 2014, or the earliest compliance date required by CMS must use predecessor form CMS-1500 (08/05). The amendments also allow a physician or noninstitutional provider to begin submitting claims using form CMS-1500 (02/12) when notified that an MCC is prepared to accept claims filed or refiled on the new form.

Adopted amendments to §21.2803(b)(3) eliminate time frames that are no longer relevant because the UB-04 claim form is now the only form institutional providers may use.

Adopted amendments to §21.2803(b)(4) delete the paragraph because the UB-92 claim form is no longer in use.

Adopted amendments to §21.2803(d) (Coordination of Benefits or Nonduplication of Benefits) add the new CMS-1500 (02/12) form, and delete obsolete forms CMS-1500 (12/90) and UB-92. Amendments to this subsection and to §21.2803(f) allow for coordination between these subsections and any successor rule to existing 28 TAC Chapter 3, Subchapter V, §§3.3501 − 3.3511 (Group Coordination of Benefits).

Adopted amendments to §21.2806 (Claims Filing Deadline) include in subsection (c) a method of claim submission listed in §21.2816 that had been omitted, and divides subsection (e) into three paragraphs to reflect that prescription benefit claims are subject to different statutory claims payment periods.

Adopted amendments to §21.2808 (Effect of Filing Deficient Claim) reflect the new statutory time limits that apply to prescription benefit claims.

An adopted amendment to §21.2809 (Audit Procedures) adds subsection (b) (Failure to Provide Notice and Payment), corrects the number of days within which a provider must notify an MCC of underpayment, and corrects the citation to the source of that number.

An adopted amendment to §21.2814 (Electronic Adjudication of Prescription Benefits) deletes from its title and text references to electronic claims because it is now applicable to all claims for prescription benefits.

Adopted amendments to §21.2815 (Failure to Meet the Statutory Claims Payment Period) conform it with Insurance Code §843.342 (Violation of Certain Claims Payment Provisions; Penalties), and §1301.137 (Violation of Claims Payment Requirements; Penalty). These Insurance Code sections were amended in 2009 to establish different penalties and interest for an MCC's late payment and underpayment of clean claims to institutional and noninstitutional providers. The amended rule also reallocates payments made to the Pool under the clean claims rules to the department on the Pool's dissolution.

Adopted amendments to §21.2819 (Catastrophic Event) correct the address to which an MCC must send a notice of a catastrophic event, and correct the titles cited for several sections within the rule.

Adopted amendments to §21.2820 (Identification Cards) add to this section the statutory requirements for exclusive provider plans, which are not identical to those for HMOs and preferred provider plans, and delete subsection (c) because the effective dates in that subsection are now obsolete.

Adopted amendments to §21.2821 (Reporting Requirements) delete the text of obsolete subsection (c), and capture the new statutory timeline for payment of electronic pharmacy claims.

An adopted amendment to §21.2825 (Severability) clarifies the scope of the rules' severability to conform it with current state law.

Adopted amendments to §21.2826 (Waiver) add Insurance Code §1211.001 (Waiver of Certain Provisions for Certain Federal Health Plans) as authority to waive

statutory and administrative provisions that do not apply to certain medical assistance plans when provided by an MCC.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

28 TAC §21.2802(17)

Comment: A commenter supports the proposed amendments, but requests that the department change the defined term "MCC or managed care carrier" to "MCO or managed care organization," here and everywhere it appears in the rule, because MCO is the term more commonly used by issuers.

Agency Response: The department declines to make this change. The term "managed care organization" is used elsewhere in the Insurance Code in a manner inconsistent with the rule's definition of "managed care carrier."

Comment: A commenter states appreciation for the department's willingness to seek and consider stakeholder responses concerning the proposed rules. The commenter also states that while they understand the department's desire for a short-hand reference to the three types of carriers subject to Subchapter T for convenience and economy of words, the department could as easily add the term "exclusive provider carrier" wherever necessary throughout the rule rather than create a term combining these carriers.

Agency Response: The department disagrees that the term "managed care carrier" should be removed from the rule and declines to make this change. As defined, the term encompasses all carriers required to comply with the clean claims requirements of Insurance Code Chapters 843 and 1301. The collective term simplifies the rule and

makes it more readable and useable by removing repetitive references to the three types of regulated carriers.

Comments: A commenter is concerned that the language *except as prohibited under federal law,* included in the proposed definition of "MCC or managed care carrier," goes beyond the scope of identifying the three types of entities covered by the subchapter, and introduces another element to the rule. The commenter points out that this added language is not necessary to create one defined term that combines the three types of entity subject to the rule. The commenter suggests that this language, new to the rule, was not deemed necessary before this proposal, and the department has demonstrated no need for the language. The commenter points out that the statute that forms the basis for the rule's definitions of "HMO," "preferred provider carrier," and "exclusive provider carrier," do not contain this term. The commenter states that the statute with which the department is required to adhere in promulgating this rule does not contain this language. The commenter believes that the language appears to be a substantive addition that: 1) is inconsistent with the underlying statutory language; 2) is not explained in the rule preamble; and 3) is unnecessary to accomplish the purported purpose of the definition, as stated in the rule preamble. The commenter urges that the language is not necessary for any of the stated purposes for the rule proposal (i.e., to implement any of the new legislation referenced in the rule preamble or to conform to any of the claim form changes). The commenter is concerned that the language may significantly increase the burden on providers and the department in enforcing the department's prompt pay rules by effectively requiring proof of an additional element

(i.e., that the "as otherwise prohibited under federal law" exception does not apply). The commenter is concerned that the language may create confusion and uncertainty in the application of the prompt pay rules, thereby potentially increasing litigation. The commenter is concerned that the language may create opportunities for issuers to attempt to avoid the application of the prompt pay law in new circumstances, such as the Affordable Care Act's 90 day grace period.

Agency Response: The department agrees that the language in question is not necessary to accomplish the department's goals in amending the rules, and has deleted the proposed language from the final rule.

28 TAC §21.2802(27)

Comment: A commenter urges that the department not adopt the proposed change to §21.2802(27) adding to the definition of "preferred provider carrier" the sentence, "The term does not include an insurer that issues an exclusive provider benefit plan." The commenter asserts that the additional sentence could create a loophole that would exempt carriers that issue both preferred provider benefit plans and exclusive provider benefit plans.

Agency Response: The department has concluded that the proposed additional sentence is unnecessary to the operation of the rule, and has deleted the sentence from the final rule.

28 TAC §21.2803(b)(1)(U)(i)

Comments: A commenter expresses support for the use of the ICD code version as an element of a clean claim, but points out that physicians' and practitioners' use of the

ICD-9CM code version will end when CMS and the NUCC make it mandatory to use the ICD-10-CM code version. The commenter suggests that this data element, captured in field 21, be eliminated as an element of a clean claim as of the date CMS and the NUCC make mandatory the use of the ICD-10-CM code version. The commenter suggests that the rule not include a specific date, as CMS and the NUCC may revise their upcoming mandatory use date.

Another commenter points out that identifying the ICD code version used is only important during the transition period between ICD-9-CM and ICD-10-CM, and that it is possible that once the ICD-9-CM is no longer used, CMS and the NUCC may decide to discontinue the use of the ICD indicator captured in field 21. The commenter suggests that if the ICD indicator is discontinued, and the rule continues to require an entry in field 21 for a claim to be clean, the requirement would create a heightened clean claim-specific standard that would be unduly burdensome for providers. The commenter suggests that §21.2803(b)(1)(U)(i) be revised to require only that "if ICD-9-CM is being used, the provider must identify ICD-9-CM by entering the number '9.'" The commenter states that "providers will be required to use the '9' indicator to designate use of ICD-9-CM for clean claims purposes and may use the '0' indicator to indicate use of ICD-10 (but will not be required to do so for clean claims purposes)." The commenter proposes that "if the indicator field remains blank, the default for processing would be that ICD-10-CM was used. If the field is improperly left blank and the ICD-9-CM was, in fact, used; [sic] then this required element for a clean claim would be missing and the claim will not be 'clean.'"

Agency Response: The department believes that in the transition period between use of the ICD-9-CM and the mandatory use of the ICD-10-CM, providers must identify precisely which ICD code version was used to file a clean claim. The department will continue requiring the entry of the '0' after use of the ICD-10-CM becomes mandatory so that claims *arising before* but *reported after* the ICD-10-CM's mandatory use date will be properly processed. The department agrees that if CMS no longer requires providers to report the code version, claims arising after the requirement is discontinued need not identify the ICD code version used to be clean claims. Section 21.2803(b)(1)(U)(i) is revised to read as follows:

"(U) for diagnosis codes or nature of illness or injury (CMS-1500 (02/12), field 21), the physician or the provider:

(i) must identify the ICD code version being used:

(I) for claims arising before the date on which CMS mandates the use of the ICD-10-CM code version for claims filed under the Medicare program, by entering either the number "9" to indicate the ICD-9-CM or the number "0" to indicate the ICD-10-CM between the vertical dotted lines in the upper right-hand portion of the field; or

(II) for claims arising on or after the date on which use of the ICD-10-CM becomes mandatory, by entering the number "0" to indicate the ICD-10-CM between the vertical, dotted lines in the upper right-hand portion of the field; or

(III) should CMS no longer require the identification of the ICD code version used, may indicate no ICD code version between the vertical dotted lines in the upper right-hand portion of the field;"

28 TAC §21.2803(b)(1)(HH)

Comment: A commenter notes that while it is not opposed to finding an alternate location for the duplicated or corrected claim designation, it objects to the proposed use of field 30 for this purpose. The commenter notes that the field is specifically reserved for NUCC use, and that NUCC would provide instructions for the field's use. The commenter expresses concern that using field 30 as proposed might jeopardize physicians' ability to meet CMS requirements in the future. As an alternative, the commenter recommends use of field 22 for this purpose, noting that field 22 is conditional and not needed in connection with an original claim submission.
The commenter suggests entering "C" for corrected claim and "D" for duplicate claim in that field.

Agency Response: The department agrees, has changed the reference in this subparagraph from field 30 to field 22, and has reordered the other subparagraphs in §21.2803(b)(1) so that the reference to field 22 appears in proper sequence. The department also agrees that it is appropriate to enter in field 22 a "C" for a corrected claim and "D" for a duplicate claim, as field 22 is an alphanumeric field.

28 TAC §21.2803(b)(2)

Comment: A commenter supports the provision allowing physicians and noninstitutional providers to begin submitting claims on the CMS-1500 (02/12) when

notified that an MCC is prepared to accept claims on the new form, and notes that an MCC may provide such notification through its website, provider newsletter, or other means so providers can easily identify which of the MCCs with which it has contracted are accepting the new form.

Agency Response: The department appreciates the commenter's support on this issue.

Comment: Another commenter states that the proposed rule requires that physicians and noninstitutional providers use predecessor form CMS-1500 (08/05) to file or refile nonelectronic clean claims before the later of April 1, 2014, or the earliest compliance date required by CMS for using successor form CMS-1500 (02/12), and only permits earlier use of the successor form on notification that the MCC is prepared to accept claims filed using the form CMS-1500 (02/12). The commenter urges the department to allow a transitional, dual use period in which a physician or noninstitutional provider could submit a claim on either the CMS-1500 (08/05) or the CMS-1500 (02/12) form before the form's mandatory use date, and before being notified that the MCC is prepared to accept and process clean claims on the new form. The commenter is concerned that early-adopting physicians already using the new form to file Medicare claims would be "unfairly penalized" because they would be required to submit different claim forms to different carriers. The commenter notes that CMS provides a dual use period between January 6, 2014, and April 1, 2014, and urges that the department allow such a dual use period. The commenter is concerned that a physician or provider submitting a claim on the new form before that form's mandatory use date, and before

being notified the carrier is ready to accept claims, may have its claim treated as not a clean claim.

Agency Response: The department declines to make this change. Not all carriers doing business in Texas participate in the Medicare program; to require a non-Medicare carrier to accept claims on the new form before its mandatory use date would unfairly penalize those carriers. A carrier that is not ready to process claims submitted on the new form before its mandatory use date may be unable to pay claims timely under the rule; to find those carriers in violation of the prompt pay deadlines would also be unfair. In 2007 the department used this same transitional structure in adopting existing §21.2803(b), implementing the CMS-1500 (08/05). To summarize, if a provider files a claim on the CMS-1500 (02/12) form before its mandatory use date and before the MCC has notified the provider that the MCC is prepared to accept a claim filed on the new form, the claim is not a clean claim. This is true even if the carrier accepts and processes the claim.

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

For with changes: Texas Association of Health Plans; Texas Medical Association.

6. STATUTORY AUTHORITY. The amendments are adopted under Insurance Code §§843.336, 1301.131, 1204.102, 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 NUCC 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 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 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.

CHAPTER 21. TRADE PRACTICES

SUBCHAPTER T. SUBMISSION OF CLEAN CLAIMS

28 TAC §§21.2801 − 21.2809 and §§21.2811 − 21.2826

§21.2801. Purpose and Scope. The purpose of this subchapter is to specify the definitions and procedures necessary to implement Insurance Code Chapters 843 and 1301 relating to clean claims and prompt payment of physician and provider claims. This subchapter applies to all nonelectronic and electronic claims submitted by contracted physicians or providers for services or benefits provided to insureds of preferred provider carriers, insureds of exclusive provider carriers, and enrollees of health maintenance organizations. The subchapter also has limited applicability to noncontracted physicians and providers. This subchapter does not apply to an exclusive provider benefit plan regulated under Chapter 3, Subchapter KK of this title (relating to Exclusive Provider Benefit Plan) written by an insurer under a contract with the Health and Human Services Commission to provide services under the Texas Children's Health Insurance Program or Medicaid.

§21.2802. Definitions. The following words and terms when used in this subchapter have the following meanings unless the context clearly indicates otherwise:

(1) Audit--A procedure authorized by and described in §21.2809 of this title (relating to Audit Procedures) under which a managed care carrier (MCC) 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 a provider. For purposes of this subchapter, billed charges must comply with all other applicable requirements of law, including Health and Safety Code §311.0025, Occupations Code §105.002, and 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 an act of God, civil or military authority, or public enemy; war, accident, fire, explosion, earthquake, windstorm, flood, or organized labor stoppage, 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 nonelectronic claims, a claim submitted by a physician or a 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 out 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 under §21.2803(d) of this title;

(B) For electronic claims, a claim submitted by a physician or a 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 MCC.

(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 a 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:

(A) corrected claims; or

(B) claims submitted by a physician or a provider at the request of the MCC.

(13) Exclusive provider carrier--An insurer that issues an exclusive provider benefit plan as provided by Insurance Code Chapter 1301.

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

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

(16) 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.

(17) MCC or managed care carrier--An HMO, a preferred provider carrier, or an exclusive provider carrier.

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

(19) Occurrence span code--The code used by the Centers for Medicare and Medicaid Services (CMS) to define a specific event relating to the billing period.

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

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

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

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

(24) Place of service code--The code used by CMS that identifies the place where the service was rendered.

(25) Point of Origin for Admission or Visit code--The code used by CMS to indicate the source of an inpatient admission.

(26) Preferred provider--

(A) with regard to a preferred provider carrier or an exclusive provider carrier, a preferred provider as defined by Insurance Code §1301.001; and

(B) with regard to an HMO:

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

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

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

(28) 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), or in a successor rule adopted by the commissioner.

(29) 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 nonelectronic claims only, this definition may also include local codes developed specifically by Medicaid, Medicare, or an MCC to describe a specific service or procedure.

(30) 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.

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

(32) Secondary plan--As defined in §3.3506 of this title, or in a successor rule adopted by the commissioner.

(33) Statutory claims payment period--

(A) the 45 calendar days during which an MCC must pay or deny a claim, in whole or in part, after receipt of a nonelectronic clean claim under Insurance Code Chapters 843 and 1301, and any extended period permitted under §21.2804 of this title (relating to Requests for Additional Information from Treating Provider) or §21.2819 of this title (relating to Catastrophic Event);

(B) the 30 calendar days during which an MCC must pay or deny a claim, in whole or in part, after receipt of an electronically submitted clean claim under Insurance Code Chapters 843 and 1301, and any extended period permitted under §21.2804 or §21.2819 of this title;

(C) the 21 calendar days during which an MCC must pay a claim after affirmative adjudication of a claim for a prescription benefit that is not electronically submitted under Insurance Code Chapters 843 and 1301 and §21.2814 of this title (relating to Adjudication of Prescription Benefits), and any extended period permitted under §21.2804 or §21.2819; or

(D) the 18 calendar days during which an MCC must make a claim payment after affirmative adjudication of an electronically submitted claim for a prescription benefit under Insurance Code Chapters 843 and 1301 and §21.2814 of this title, and any extended period permitted under §21.2804 or §21.2819 of this title.

(34) Subscriber--If individual coverage, the individual who is the contract holder and is responsible for payment of premiums to the MCC; 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 MCC.

(35) Type of bill code--The three-digit alphanumeric code used 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 a provider submits a clean claim by providing to an MCC or any other entity designated for receipt of claims under §21.2811 of this title (related to Disclosure of Processing Procedures):

(1) for nonelectronic claims other than dental claims, the required data elements specified in subsection (b) of this section;

(2) for nonelectronic dental claims filed with an HMO, the required data elements specified in subsection (c) of this section;

(3) 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

(4) if applicable, any coordination of benefits or nonduplication of benefits information under subsection (d) of this section.

(b) Required data elements. CMS has developed claim forms that 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) - (3) of this subsection are based on the terms CMS used on successor forms CMS-1500 (02/12), CMS-1500 (08/05), UB-04 CMS-1450, and UB-04. The parenthetical information following each term and data element 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 refiled by physicians or noninstitutional providers are set out in paragraphs (1) and (2) of this subsection. Mandatory form usage dates and optional form transition dates for

nonelectronic claims filed or refiled by institutional providers are set out in paragraph (3) of this subsection.

(1) Required form and data elements for physicians or noninstitutional providers for claims filed or refiled on or after the later of April 1, 2014, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (02/12) claim form for Medicare claims. The CMS-1500 (02/12) claim form and the data elements described in this paragraph are required for claims filed or refiled by physicians or noninstitutional providers on or after the later of these two dates: April 1, 2014, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (02/12) claim form for Medicare claims. The CMS-1500 (02/12) claim form must be completed in compliance with the special instructions applicable to the data elements as described by this paragraph for clean claims filed by physicians and noninstitutional providers. Further, on notification that an MCC is prepared to accept claims filed or refiled on form CMS-1500 (02/12), a physician or noninstitutional provider may submit claims on form CMS-1500 (02/12) before the mandatory use date described in this paragraph, subject to the required data elements set out in this paragraph.

(A) subscriber's or patient's plan ID number (CMS-1500 (02/12), field 1a) is required;

(B) patient's name (CMS-1500 (02/12), field 2) is required;

(C) patient's date of birth and sex (CMS-1500 (02/12), field 3) are required;

(D) subscriber's name (CMS-1500 (02/12), field 4) is required if shown on the patient's ID card;

(E) patient's address (street or P.O. Box, city, state, ZIP Code) (CMS-1500 (02/12), field 5) is required;

(F) patient's relationship to subscriber (CMS-1500 (02/12), field 6) is required;

(G) subscriber's address (street or P.O. Box, city, state, ZIP Code) (CMS-1500 (02/12), field 7) is required, but the physician or the 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 (02/12), 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 subparagraph (N) of this paragraph, "disclosure of any other health benefit plans," is answered "Yes," this element is required unless the physician or the provider submits with the claim documented proof that the physician or the provider has made a good faith but unsuccessful attempt to obtain from the enrollee or the insured any of the information needed to complete this data element;

(I) other insured's or enrollee's policy or group number (CMS-1500 (02/12), 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 subparagraph (N) of this paragraph, "disclosure of any other

health benefit plans," is answered "Yes," this element is required unless the physician or the provider submits with the claim documented proof that the physician or the provider has made a good faith but unsuccessful attempt to obtain from the enrollee or the insured any of the information needed to complete this data element;

(J) other insured's or enrollee's HMO or insurer name (CMS-1500 (02/12), 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 subparagraph (N) of this paragraph, "disclosure of any other health benefit plans," is answered "Yes," this element is required unless the physician or the provider submits with the claim documented proof that the physician or the provider has made a good faith but unsuccessful attempt to obtain from the enrollee or the insured any of the information needed to complete this data element;

(K) whether the patient's condition is related to employment, auto accident, or other accident (CMS-1500 (02/12), field 10) is required, but facility-based radiologists, pathologists, or anesthesiologists must enter "N" if the answer is "No" or if the information is not available;

(L) subscriber's policy number (CMS-1500 (02/12), field 11) is required;

(M) HMO or insurance company name (CMS-1500 (02/12), field 11c) is required;

(N) disclosure of any other health benefit plans (CMS-1500 (02/12), field 11d) is required;

(i) if answered “Yes,” then:

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

(II) when submitting claims to secondary payor MCCs the data element specified in subparagraph (GG) of this paragraph is required;

(ii) if answered “No,” the data elements specified in subparagraphs (H) – (J) of this paragraph are not required if the physician or the 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 the provider must submit a copy of the signed document to the MCC on request;

(O) patient’s or authorized person’s signature or a notation that the signature is on file with the physician or the provider (CMS-1500 (02/12), field 12) is required;

(P) subscriber’s or authorized person’s signature or a notation that the signature is on file with the physician or the provider (CMS-1500 (02/12), field 13) is required;

(Q) date of injury (CMS-1500 (02/12), field 14) is required if due to an accident;

(R) when applicable, the physician or the provider must enter the name of the referring primary care physician, specialty physician, hospital, or other source (CMS-1500 (02/12), field 17). However, if there is no referral, the physician or the provider must enter “Self-referral” or “None”;

(S) if there is a referring physician noted in CMS-1500 (02/12), field 17, the physician or the provider must enter the ID Number of the referring primary care physician, specialty physician, or hospital (CMS-1500 (02/12), field 17a);

(T) if there is a referring physician noted in CMS-1500 (02/12), field 17, the physician or the provider must enter the NPI number of the referring primary care physician, specialty physician, or hospital (CMS-1500 (02/12), field 17b) if the referring physician is eligible for an NPI number;

(U) for diagnosis codes or nature of illness or injury (CMS-1500 (02/12), field 21), the physician or the provider:

(i) must identify the ICD code version being used:

(I) for all claims arising before the date on which CMS mandates the use of the ICD-10-CM for claims filed under the Medicare program, by entering either the number “9” to indicate the ICD-9-CM or the number “0” to indicate the ICD-10-CM between the vertical, dotted lines in the upper right-hand portion of the field;

(II) for all claims arising on or after the date on which CMS mandates the use of the ICD-10-CM for claims filed under the Medicare program,

by entering the number “0” to indicate the ICD-10-CM between the vertical, dotted lines in the upper right-hand portion of the field;

(III) should CMS no longer require identification of the ICD code version being used, may indicate no ICD code version between the vertical dotted lines in the upper right-hand portion of the field;

(ii) must enter at least one diagnosis code, and

(iii) may enter up to 12 diagnosis codes, but the primary diagnosis must be entered first;

(V) if the claim is a duplicate claim, a “D” is required; if the claim is a corrected claim, a “C” is required (CMS-1500 (02/12), field 22);

(W) verification number is required (CMS-1500 (02/12), field 23) if services have been verified as provided by §19.1719 of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans). If no verification has been provided, a prior authorization number (CMS-1500 (02/12), field 23) is required when prior authorization is required and granted;

(X) date(s) of service (CMS-1500 (02/12), field 24A) is required;

(Y) place of service code(s) (CMS-1500 (02/12), field 24B) is required;

(Z) procedure/modifier code(s) (CMS-1500 (02/12), field 24D) is required. If a physician or a provider uses an unlisted or not classified procedure code or a National Drug Code (NDC), the physician or provider must enter a narrative

description of the procedure or the NDC in the shaded area above the corresponding completed service line;

(AA) diagnosis code by specific service (CMS-1500 (02/12), field 24E) is required with the first code linked to the applicable diagnosis code for that service in field 21;

(BB) charge for each listed service (CMS-1500 (02/12), field 24F) is required;

(CC) number of days or units (CMS-1500 (02/12), field 24G) is required;

(DD) the NPI number of the rendering physician or provider (CMS-1500 (02/12), field 24J, unshaded portion) is required if the rendering provider is not the billing provider listed in CMS-1500 (02/12), field 33, and if the rendering physician or provider is eligible for an NPI number;

(EE) physician's or provider's federal tax ID number (CMS-1500 (02/12), field 25) is required;

(FF) whether assignment was accepted (CMS-1500 (02/12), field 27) is required if assignment under Medicare has been accepted;

(GG) total charge (CMS-1500 (02/12), field 28) is required;

(HH) amount paid (CMS-1500 (02/12), field 29) is required if an amount has been paid to the physician or the provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber or by a primary plan in

compliance with subparagraph (N) of this paragraph and as required by subsection (d) of this section;

(II) signature of physician or provider or a notation that the signature is on file with the MCC (CMS-1500 (02/12), field 31) is required;

(JJ) name and address of the facility where services were rendered, if other than home, (CMS-1500 (02/12), field 32) is required;

(KK) the NPI number of the facility where services were rendered, if other than home, (CMS-1500 (02/12), field 32a) is required if the facility is eligible for an NPI;

(LL) physician's or provider's billing name, address, and telephone number (CMS-1500 (02/12), field 33) is required;

(MM) the NPI number of the billing provider (CMS-1500 (02/12), field 33a) is required if the billing provider is eligible for an NPI number; and

(NN) provider number (CMS-1500 (02/12), field 33b) is required if the MCC required provider numbers and gave notice of the requirement to physicians and providers before June 17, 2003.

(2) Required form and data elements for physicians or noninstitutional providers for claims filed or refiled before the later of April 1, 2014, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (02/12) claim form for Medicare claims. The CMS-1500 (08/05) claim form and the data elements described in this paragraph are required for claims filed or refiled by physicians or noninstitutional providers before the later of these two dates: April 1, 2014, or the

earliest compliance date required by CMS for mandatory use of the CMS-1500 (02/12) claim form for Medicare claims. The CMS-1500 (08/05) claim form must be completed in compliance with the special instructions applicable to the data element as described in this paragraph for clean claims filed by physicians and noninstitutional providers. However, on notification that an MCC is prepared to accept claims filed or refiled on form CMS-1500 (02/12), a physician or noninstitutional provider may submit claims on form CMS-1500 (02/12) before the subsection (b)(1) of this section mandatory use date described in this paragraph, subject to the subsection (b)(1) of this section required data elements set out in the paragraph.

(A) subscriber's or 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 sex (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 Code) (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 Code) (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 subparagraph (Q) of this paragraph, "disclosure of any other health benefit plans," is answered "Yes," this element is required unless the physician or the provider submits with the claim documented proof that the physician or the provider has made a good faith but unsuccessful attempt to obtain from the enrollee or the insured any of the information needed to complete this data element;

(I) other insured's or enrollee's policy or 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 subparagraph (Q) of this paragraph, "disclosure of any other health benefit plans," is answered "Yes," this element is required unless the physician or the provider submits with the claim documented proof that the physician or the provider has made a good faith but unsuccessful attempt to obtain from the enrollee or the 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 subparagraph (Q) of this paragraph, "disclosure of any other health

benefit plans," is answered "Yes," this element is required unless the physician or the provider submits with the claim documented proof that the physician or the provider has made a good faith but unsuccessful attempt to obtain from the enrollee or the 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 subparagraph (Q) of this paragraph, "disclosure of any other health benefit plans," is answered "Yes," this element is required unless the physician or the provider submits with the claim documented proof that the physician or the provider has made a good faith but unsuccessful attempt to obtain from the enrollee or the insured any of the information needed to complete this data element. If the field is required and the physician or the provider is a facility-based radiologist, pathologist, or anesthesiologist with no direct patient contact, the physician or the 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 subparagraph (Q) of this paragraph, "disclosure of any other health benefit plans," is answered "Yes," this element is required unless the physician or the provider submits with the claim documented proof that the physician or the provider

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

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

(II) the data element specified in subparagraph (KK) of this paragraph is required when submitting claims to secondary payor MCCs;

(ii) if answered "No," the data elements specified in subparagraphs (H) – (L) of this paragraph are not required if the physician or the 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 the provider must submit a copy of the signed document to the MCC on request;

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

(S) subscriber's or authorized person's signature or a notation that the signature is on file with the physician or the 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 the provider must 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 the provider must enter "Self-referral" or "None";

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

(W) if there is a referring physician noted in CMS-1500 (08/05), field 17, the physician or the provider must 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 a provider uses an unlisted or unclassified 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. At least one is required, but the primary diagnosis must be entered first;

(Z) verification number (CMS-1500 (08/05), field 23) is required if services have been verified under §19.1719 of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans). 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) 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 the provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber or by a primary plan to comply with subparagraph (Q) of this paragraph and as required by subsection (d) of this section;

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

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

(NN) the NPI number of the facility where services were rendered, if other than home, (CMS-1500 (08/05), field 32a) is required 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) the NPI number of the 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 MCC required provider numbers and gave notice of the requirement to physicians and providers before June 17, 2003.

(3) Required form and data elements for institutional providers. The UB-04 claim form and the data elements described in this paragraph are required for claims filed or refiled by institutional providers. The UB-04 claim form must be completed under the special instructions applicable to the data elements as described by this paragraph for clean claims filed by institutional providers.

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

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

(C) type of bill code (UB-04, field 4) is required and must 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 sex (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 (such as emergency, urgent, elective, newborn) (UB-04, field 14) is required for admissions;

(M) point of origin for admission or visit 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 discharge status 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, and may be entered as value code "01" if no value codes are applicable to the inpatient admission;

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

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

(V) Healthcare Common Procedure Coding System (HCPCS) codes or 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) MCC name (UB-04, field 50) is required;

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

(CC) 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, before 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 or subscriber's certificate number, health claim number, and ID number (UB-04, field 60) are 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 under §19.1719 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) diagnosis 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 if the attending physician is eligible for an NPI number; and

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

(c) Required data elements for dental claims. The data elements described in this subsection are required as indicated and must be completed or provided under the special instructions applicable to the data elements for nonelectronic 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 sex is required;

(5) patient’s relationship to subscriber is required;

(6) subscriber’s name is required;

(7) subscriber's address is required, but the 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 sex is required;

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

(11) subscriber's plan or 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 must include a "No" if the patient is not covered by another plan providing dental benefits. If the patient does have other coverage, the provider must indicate "Yes," and the elements in paragraphs (15) − (20) of this subsection are required unless the provider submits with the claim documented proof 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 as called for by the response to and requirements of paragraph (14) of this subsection;

(16) other insured's or enrollee's date of birth is required as called for by the response to and requirements of the element in paragraph (14) of this subsection;

(17) other insured's or enrollee's sex is required as called for by the response to and requirements of the element in paragraph (14) of this subsection;

(18) other insured's or enrollee's identification number is required as called for by the response to and requirements of the element in paragraph (14) of this subsection;

(19) patient's relationship to other insured or enrollee is required as called for by the response to and requirements of the element in paragraph (14) of this subsection;

(20) name of other HMO or insurer is required as called for by the response to and requirements of the element in paragraph (14) 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 must 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 (33) and (34) 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 nonduplication of benefits.

(1) If a claim is submitted for covered services or benefits for which coordination of benefits is necessary under §§3.3501 − 3.3511 of this title (relating to Group Coordination of Benefits), a successor rule adopted by the commissioner, or §11.511(1) of this title (relating to Optional Provisions), 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 claim processing and CMS-1500 (02/12), field 29, or CMS-1500 (08/05), field 29, or UB-04, field 54, as applicable, must be completed under subsection (b)(1)(GG), (2)(KK), and (3)(BB) of this section.

(2) If a claim is submitted for covered services or benefits for which nonduplication of benefits under §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 (02/12), field 29, or CMS-1500 (08/05), field 29, or UB-04, field 54, as applicable, must be completed under subsection (b)(1)(GG), (2)(KK), and (3)(BB) of this section.

(3) If a claim is submitted for covered services or benefits and the policy contains a variable deductible provision as set out 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 (02/12), field 29, or CMS-1500 (08/05), field 29, or UB-04, field 54, as applicable,

must be completed under subsection (b)(1)(GG), (2)(KK), and (3)(BB) of this section. Despite these requirements, an MCC may not require a physician or a provider to investigate coordination of other health benefit plan coverage.

(e) Submission of electronic clean claim. A physician or a provider submits an electronic clean claim by 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) Coordination of benefits on electronic clean claims. If a physician or a provider submits an electronic clean claim that requires coordination of benefits under §§3.3501 − 3.3511 of this title, a successor rule adopted by the commissioner, or §11.511(1) of this title, the MCC processing the claim as a secondary payor must rely on the primary payor information submitted on the claim by the physician or the 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 out in subsections (b) – (f) of this section, as applicable, 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 a provider in addition to those required for a clean claim under this section does not render such claim deficient.

§21.2804. Requests for Additional Information from Treating Preferred Provider.

(a) If necessary to determine whether a claim is payable, an MCC may, within 30 days of receipt of a clean claim, request additional information from the treating preferred provider. The time to request additional information may be extended as allowed by §21.2819(c) of this title (relating to Catastrophic Event). An MCC may make only one request to the submitting treating preferred provider for information under this section.

(b) A request for information under this section must:

(1) be in writing;

(2) be specific to the claim or the claim's related episode of care;

(3) describe with specificity the clinical and other information to be included in the response;

(4) be relevant and necessary for the resolution of the claim; and

(5) be for information that is contained in or in the process of being incorporated into the patient's medical or billing record maintained by the preferred provider.

(c) An MCC that requests information under this section must determine whether the claim is payable and pay or deny the claim, or audit the claim in compliance with §21.2809 of this title (relating to Audit Procedures), on or before the later of:

(1) the 15th day after the date the MCC receives the requested information as required under subsection (e) of this section;

(2) the 15th day after the date the MCC receives a response under subsection (d) of this section; or

(3) the latest date for determining whether the claim is payable under §21.2807 of this title (relating to Effect of Filing a Clean Claim).

(d) If a preferred provider does not possess the requested information, the preferred provider must submit a written response indicating that the preferred provider does not possess the requested information in order to resume the claims payment period as described in subsection (c) of this section.

(e) An MCC must require the preferred provider responding to a request made under this section to either attach a copy of the request to the response or include with the response the name of the patient, the patient identification number, the claim number as provided by the MCC, the date of service, and the name of the treating preferred provider. If the MCC submitted the request for additional information electronically in compliance with federal requirements concerning electronic transactions, the treating preferred provider must submit the response in compliance with those requirements. To resume the claims payment period as described in subsection (c) of this section, the treating preferred provider must deliver the requested information in compliance with this subsection.

(f) Receipt of a request or a response to a request under this section is subject to the provisions of §21.2816 of this title (relating to Date of Receipt).

§21.2805. Requests for Additional Information from Other Sources.

(a) If an MCC requests additional information from a person other than the preferred provider who submitted the claim, the MCC must provide to the preferred provider who submitted the claim a notice containing the name of the physician, the

provider, or the other entity from which the MCC is requesting information. The MCC may not withhold payment beyond the applicable statutory claims payment period pending receipt of information requested under subsection (b) of this section. If, on receiving information requested under this subsection the MCC determines that there was an error in payment of the claim, the MCC may recover any overpayment under §21.2818 of this title (relating to Overpayment of Claims).

(b) An MCC must request that the entity responding to a request made under this section attach a copy of the request to the response. If the request for additional information was submitted electronically in compliance with applicable federal requirements concerning electronic transactions, the responding entity must submit the response in compliance with those requirements, if applicable.

(c) Receipt of a request or a response to a request under this section is subject to the provisions of §21.2816 of this title (relating to Date of Receipt).

§21.2806. Claim Filing Deadline.

(a) Claim submission deadline. A physician or a provider must submit a claim to an MCC not later than the 95th day after the date the physician or the provider delivers the medical care or health care services for which the claim is made. An MCC and a physician or a provider may agree, by contract, to extend the period for submitting a claim. For a claim submitted by an institutional provider, the 95-day period does not begin until the date of discharge. For a claim for which coordination of benefits applies, the 95-day period does not begin for submission of the claim to the secondary payor

until the physician or the provider receives notice of the payment or the denial from the primary payor.

(b) Failure to meet claim submission deadline. If a physician or a provider fails to submit a claim in compliance with this section, the physician or the provider forfeits the right to payment unless the physician or the provider has certified that the failure to timely submit the claim is a result of a catastrophic event in compliance with §21.2819 of this title (relating to Catastrophic Event).

(c) Manner of claim submission. A physician or a provider may submit claims by United States mail, first class; United States mail, return receipt requested; overnight delivery service; electronic transmission; hand delivery; facsimile, if the MCC accepts claims submitted by facsimile; or as otherwise agreed to by the physician or the provider and the MCC. An MCC must accept as proof of timely filing a claim filed in compliance with this subsection or information from another MCC showing that the physician or the provider submitted the claim to the other MCC in compliance with this subsection.

(d) Determining date of submission. Section 21.2816 of this title (relating to Date of Receipt) determines the date an MCC receives a claim.

(e) Duplicate claims.

(1) A physician or a provider may not submit a duplicate claim before the 46th day, or the 31st day if filed electronically, after the date the original claim is received according to the provisions of §21.2816 of this title, except as provided in paragraph (2) of this subsection for prescription benefit claims.

(2) A physician or a provider may not submit a duplicate claim for prescription benefits before the 22nd day, or the 19th day if filed electronically, after the date the original claim is received according to the provisions of §21.2816 of this title.

(3) An MCC that receives a duplicate claim before the applicable date specified in paragraphs (1) and (2) of this subsection is not subject to the provisions of §21.2807 of this title (relating to Effect of Filing a Clean Claim) or §21.2815 of this title (relating to Failure to Meet the Statutory Claims Payment Period) with respect to the duplicate claim.

§21.2807. Effect of Filing a Clean Claim.

(a) The statutory claims payment period begins to run on receipt of a clean claim, including a corrected claim that is a clean claim, from a preferred provider, under §21.2816 of this title (relating to Date of Receipt), at the address designated by the MCC, in compliance with §21.2811 of this title (relating to Disclosure of Processing Procedures), whether it be the address of the MCC or any other entity, including a clearinghouse or a repricing company, designated by the MCC to receive claims. The date of claim payment is determined in §21.2810 of this title (relating to Date of Claim Payment).

(b) After receipt of a clean claim and before the expiration of the applicable statutory claims payment period specified in §21.2802 of this title (relating to Definitions), an MCC must:

(1) pay the total amount of the clean claim as specified in the contract between the preferred provider and the MCC;

(2) deny the clean claim in its entirety after a determination that the MCC is not liable for the clean claim and notify the preferred provider in writing why the clean claim will not be paid;

(3) notify the preferred provider in writing that the entire clean claim will be audited and pay 100 percent of the contracted rate on the claim to the preferred provider; or

(4) pay the portion of the clean claim for which the MCC acknowledges liability as specified in the contract between the preferred provider and the MCC, and:

(A) deny the remainder of the clean claim after a determination that the MCC is not liable for the remainder of the clean claim and notify the preferred provider in writing why the remainder of the clean claim will not be paid; or

(B) notify the preferred provider in writing that the remainder of the clean claim will be audited and pay 100 percent of the contracted rate on the unpaid portion of the clean claim to the preferred provider.

(c) An MCC or an MCC's clearinghouse that receives an electronic clean claim is subject to the requirements of this subchapter regardless of whether the claim is submitted together with, or in a batch submission with, a claim that is deficient.

§21.2808. Effect of Filing a Deficient Claim. If an MCC determines that a submitted claim is deficient, the MCC must notify the preferred provider submitting the claim that the claim is deficient within 45 calendar days of the MCC's receipt of the nonelectronic claim, or within 30 days of receipt of an electronic claim. If an MCC determines that a claim for a prescription benefit is deficient, the MCC must notify the provider that the

claim is deficient within 21 calendar days of the MCC's receipt of the nonelectronic claim, or within 18 days of receipt of an electronic claim.

§21.2809. Audit Procedures.

(a) Notice and payment required. If an MCC is unable to pay or deny a clean claim, in whole or in part, within the applicable statutory claims payment period specified in §21.2802 of this title (relating to Definitions) and intends to audit the claim to determine whether the claim is payable, the MCC must notify the preferred provider that the claim is being audited and pay 100 percent of the contracted rate within the applicable statutory claims payment period.

(b) Failure to provide notice and payment. An MCC that fails to provide notice of the decision to audit the claim and pay 100 percent of the applicable contracted rate subject to copayments and deductibles within the applicable statutory claims payment period, or, if applicable, the extended periods allowed for by §21.2804(c) of this title (relating to Requests for Additional Information from Treating Preferred Provider) or §21.2819(c) of this title (relating to Catastrophic Event), may not make use of the audit procedures set out in this section. A preferred provider that receives less than 100 percent of the contracted rate with a notice of intent to audit has received an underpayment and must notify the MCC within 270 days in compliance with the provisions of §21.2815(f)(2) of this title (relating to Failure to Meet the Statutory Claims Payment Period) to qualify to receive a penalty for the underpaid amount.

(c) Explanation of payment. The MCC must clearly indicate on the explanation of payment that the claim is being audited and that the preferred provider is being paid 100

percent of the contracted rate, subject to completion of the audit. A nonelectronic explanation of payment complies with this requirement if the notice of the audit is clearly and prominently identified.

(d) Audit deadline and requirements. The MCC must complete the audit within 180 calendar days from receipt of the clean claim. The HMO or preferred provider carrier must provide written notice of the results of the audit. The MCC must include in the notice a listing of the specific claims paid and not paid under the audit, as well as a listing of specific claims and amounts for which a refund is due and, for each claim, the basis and specific reasons for requesting a refund. An MCC seeking recovery of any refund under this section must comply with the procedures set out in §21.2818 of this title (relating to Overpayment of Claims).

(e) Requests for information. An MCC may recover the total amount paid on the claim under subsection (a) of this section if a physician or a provider fails to timely provide additional information requested under the requirements of Insurance Code §1301.105 or §843.340(c). Section 21.2816 of this title (relating to Date of Receipt) applies to the submission and receipt of a request for information under this subsection.

(f) Opportunity for appeal. Before seeking a refund for a payment made under this section, an MCC must provide a preferred provider with the opportunity to appeal the request for a refund in compliance with §21.2818 of this title. An MCC may not seek to recover the refund until all of the preferred provider's internal appeal rights under §21.2818 of this title have been exhausted.

(g) No admission of liability. Payments made under this section on a clean claim are not an admission that the MCC acknowledges liability on that claim.

§21.2811. Disclosure of Processing Procedures.

(a) In contracts with preferred providers, or in the physician or the provider manual or other document that sets forth the procedure for filing claims, or by any other method mutually agreed on by the contracting parties, an MCC must disclose to its preferred providers:

(1) the address, including a physical address, where claims are to be sent for processing;

(2) the telephone number to which preferred providers' questions and concerns regarding claims may be directed;

(3) any entity, along with its address, including physical address and telephone number, to which the MCC has delegated claim payment functions; and

(4) the mailing address, physical address, and telephone number of any separate claims processing centers for specific types of services.

(b) An MCC must provide no less than 60 calendar days' prior written notice of any changes of address for submission of claims, and of any changes of delegation of claims payment functions, to all affected preferred providers.

§21.2812. Denial of Clean Claim Prohibited for Change of Address. After a change of claims payment address or a change in delegation of claims payment functions, an MCC may not premise the denial of a clean claim on a preferred provider's failure to file a claim within the claim filing deadline set out in §21.2806 of this title (relating to Claim

Filing Deadline), unless the MCC has given timely written notice as required by §21.2811(b) of this title (relating to Disclosure of Processing Procedures).

§21.2813. Requirements Applicable to Other Contracting Entities. Any contract or delegation agreement between an MCC and an entity that processes or pays claims, obtains the services of physicians and providers to provide health care services, or issues verifications or preauthorizations may not limit the MCC's authority or responsibility to comply with all applicable statutory and regulatory requirements.

§21.2814. Adjudication of Prescription Benefits. If a prescription benefit does not require authorization by an MCC, the statutory claims payment period must begin on the date of affirmative adjudication of the claim for a prescription benefit.

§21.2815. Failure to Meet the Statutory Claims Payment Period.

(a) An MCC that determines under §21.2807 of this title (relating to Effect of Filing a Clean Claim) that a claim is payable must pay the contracted rate owed on the claim; and:

(1) if the claim is paid on or before the 45th day after the end of the applicable statutory claims payment period, pay to a noninstitutional preferred provider a penalty in the amount of the lesser of:

(A) 50 percent of the difference between the billed charges and the contracted rate; or

(B) $100,000;

(2) if the claim is paid on or after the 46th day and before the 91st day after the end of the applicable statutory claims payment period, pay to a noninstitutional preferred provider, a penalty in the amount of the lesser of:

(A) 100 percent of the difference between the billed charges and the contracted rate; or

(B) $200,000;

(3) if the claim is paid on or after the 91st day after the end of the applicable statutory claims payment period:

(A) pay to the noninstitutional preferred provider a penalty computed under paragraph (2) of this subsection; and

(B) pay to the Texas Health Insurance Pool until its dissolution, and after its dissolution to the Texas Department of Insurance (department) 18 percent annual interest on the penalty amount paid to a noninstitutional preferred provider under paragraph (2) of this subsection. Interest under this paragraph accrues beginning on the date the MCC was required to pay the claim and ending on the date the claim and the penalty are paid in full to the noninstitutional provider;

(4) if the claim is paid to an institutional preferred provider on or before the 45th day after the end of the applicable statutory claims payment period, pay a penalty in the amount specified in subparagraph (A) or (B) of this paragraph. The MCC must pay 50 percent of the penalty to the institutional preferred provider and 50 percent of the penalty to the Texas Health Insurance Pool until its dissolution, and after its dissolution to the department. The penalty under this paragraph is in the amount of the lesser of:

(A) 50 percent of the difference between the billed charges and the contracted rate; or

(B) $100,000;

(5) if the claim is paid to an institutional preferred provider on or after the 46th day and before the 91st day after the end of the applicable statutory claims payment period, pay a penalty in the amount specified in subparagraph (A) or (B) of this paragraph. The MCC must pay 50 percent of the penalty to the institutional preferred provider and 50 percent of the penalty to the Texas Health Insurance Pool until its dissolution, and after its dissolution to the department. The penalty under this paragraph is in the amount of the lesser of:

(A) 100 percent of the difference between the billed charges and the contracted rate; or

(B) $200,000; and

(6) if the claim is paid to an institutional preferred provider on or after the 91st day after the end of the applicable statutory claims payment period:

(A) pay the penalty amount to the institutional provider and the Texas Health Insurance Pool until its dissolution, and after its dissolution to the department as specified in paragraph (5) of this subsection; and

(B) pay 18 percent annual interest on the penalty amount computed under paragraph (5) of this subsection. Interest under this paragraph accrues beginning on the date the MCC was required to pay the claim and ending on the date the claim and the institutional provider's portion of the penalty are paid in full. The MCC must pay

50 percent of the interest to the institutional preferred provider and 50 percent of the interest to the Texas Health Insurance Pool until its dissolution, and after its dissolution to the department.

(b) The following examples demonstrate how to calculate penalty amounts under subsection (a)(1) − (3) of this section:

(1) if the contracted rate, including any patient financial responsibility, is $10,000 and the billed charges are $15,000, and the MCC pays the claim on or before the 45th day after the end of the applicable statutory claims payment period, the MCC must pay, in addition to the amount owed on the claim, 50 percent of the difference between the billed charges ($15,000) and the contracted rate ($10,000) or $2,500. The basis for the penalty is the difference between the total contracted amount, including any patient financial responsibility, and the noninstitutional provider's billed charges;

(2) if the claim is paid on or after the 46th day and before the 91st day after the end of the applicable statutory claims payment period, the MCC must pay, in addition to the contracted rate owed on the claim, 100 percent of the difference between the billed charges and the contracted rate or $5,000; and

(3) if the claim is paid on or after the 91st day after the end of the applicable statutory claims payment period, the MCC must pay to the noninstitutional provider, in addition to the contracted rate owed on the claim, the $5,000 penalty. The MCC must also pay to the Texas Health Insurance Pool until its dissolution, and after its dissolution to the department 18 percent annual interest on the $5,000 penalty amount

accruing from the statutory claim payment deadline until the date the claim and penalty are paid in full to the noninstitutional provider.

(c) Except as provided by this section, an MCC that determines under §21.2807 of this title that a claim is payable, pays only a portion of the amount of the claim on or before the end of the applicable statutory claims payment period, and pays the balance of the contracted rate owed for the claim after that date must, in addition to paying the contracted amount owed:

(1) if the balance of the claim is paid to a noninstitutional preferred provider on or before the 45th day after the applicable statutory claims payment period, pay to the preferred provider a penalty on the amount not timely paid in the amount of the lesser of:

(A) 50 percent of the underpaid amount; or

(B) $100,000;

(2) if the balance of the claim is paid to a noninstitutional preferred provider on or after the 46th day and before the 91st day after the end of the applicable statutory claims payment period, pay to the preferred provider a penalty in the amount of the lesser of:

(A) 100 percent of the underpaid amount; or

(B) $200,000;

(3) if the balance of the claim is paid to a noninstitutional preferred provider on or after the 91st day after the end of the applicable statutory claims payment period, pay to the preferred provider a penalty computed under paragraph (2) of this

subsection plus 18 percent annual interest on the penalty amount. Interest under this subsection accrues beginning on the date the MCC was required to pay the claim and ending on the date the claim and the penalty are paid in full;

(4) if the balance of the claim is paid to an institutional preferred provider on or before the 45th day after the applicable statutory claims payment period, pay a penalty in the amount specified in subparagraphs (A) and (B) of this paragraph. The MCC must pay 50 percent of the penalty to the institutional preferred provider and 50 percent of the penalty to the Texas Health Insurance Pool until its dissolution, and after its dissolution to the department. The penalty under this paragraph on the amount not timely paid is in the amount of the lesser of:

(A) 50 percent of the underpaid amount; or

(B) $100,000;

(5) if the balance of the claim is paid to an institutional preferred provider on or after the 46th day and before the 91st day after the end of the applicable statutory claims payment period, pay a penalty in the amount specified in subparagraphs (A) and (B) of this paragraph. The MCC must pay 50 percent of the penalty to the institutional preferred provider and 50 percent of the penalty to the Texas Health Insurance Pool until its dissolution, and after its dissolution to the department. The penalty under this paragraph is in the amount of the lesser of:

(A) 100 percent of the underpaid amount; or

(B) $200,000; and

(6) if the balance of the claim is paid to an institutional preferred provider on or after the 91st day after the end of the applicable statutory claims payment period, pay a penalty computed under paragraph (5) of this subsection plus 18 percent annual interest on the penalty amount. Interest under this subsection accrues beginning on the date the MCC was required to pay the claim and ending on the date the claim and the institutional provider's portion of the penalty are paid in full. The MCC must pay 50 percent of the interest to the institutional preferred provider and 50 percent of the interest to the Texas Health Insurance Pool until its dissolution, and after its dissolution to the department.

(d) For the purposes of subsection (c) of this section, the underpaid amount is calculated on the ratio of the balance owed by the MCC to the total contracted rate, including any patient financial responsibility, as applied to an amount equal to the billed charges minus the contracted rate. For example, a claim for a contracted rate to a noninstitutional preferred provider of $1,000 and billed charges of $1,500 is initially underpaid at $600, with the insured owing $200 and the MCC owing a balance of $200. The MCC pays the $200 balance on the 30th day after the end of the applicable statutory claims payment period. The amount the MCC initially underpaid, $200, is 20 percent of the contracted rate. To determine the penalty, the MCC must calculate 20 percent of the billed charges minus the contracted rate, which is $100. This amount represents the underpaid amount for subsection (c)(1) of this section. The MCC must pay, as a penalty, 50 percent of $100, or $50.

(e) For purposes of calculating a penalty when an MCC is a secondary plan MCC for a claim, the contracted rate and billed charges must be reduced in proportion to the percentage of the entire claim that is owed by the secondary plan MCC. The following example illustrates this method: Carrier A pays 80 percent of a claim to a noninstitutional preferred provider for a contracted rate of $1,000 and billed charges of $1,500, leaving $200 unpaid as the patient's financial responsibility. The patient has coverage through Carrier B that is secondary, and Carrier B will owe the $200 balance under the coordination of benefits provision of Carrier B's policy. If Carrier B fails to pay the $200 within the applicable statutory claims payment period, Carrier B will pay a penalty based on the percentage of the claim that it owed. The contracted rate for Carrier B will be $200 (20 percent of Carrier A's $1,000 contracted rate), and the billed charges will be $300 (20 percent of $1,500). Although Carrier B may have a contracted rate with the provider that is different from Carrier A's contracted rate, it is Carrier A's contracted rate that establishes the entire claim amount for the purpose of calculating Carrier B's penalty.

(f) An MCC is not liable for a penalty under this section:

(1) if the failure to pay the claim within the applicable statutory claims payment period is a result of a catastrophic event that the MCC certified according to the provisions of §21.2819 of this title (relating to Catastrophic Event); or

(2) if the claim was paid in compliance with §21.2807 of this title, but for less than the contracted rate, and:

(A) the preferred provider notifies the MCC of the underpayment after the 270th day after the date the underpayment was received; and

(B) the MCC pays the balance of the claim on or before the 30th day after the date the insurer receives the notice of underpayment.

(g) Subsection (f) of this section does not relieve the MCC of the obligation to pay the remaining unpaid contracted rate owed the preferred provider.

(h) An MCC that pays a penalty under this section must clearly indicate on the explanation of payment the amount of the contracted rate paid, the amount of the billed charges as submitted by the physician or the provider, and the amount paid as a penalty. A nonelectronic explanation of payment complies with this requirement if it clearly and prominently identifies the notice of the penalty amount.

§21.2816. Date of Receipt.

(a) A written communication, including a claim, referenced under this subchapter is subject to and must comply with this section unless otherwise stated in this subchapter.

(b) An entity subject to these rules may deliver written communications as follows:

(1) submit the communication by United States mail, first class; by United States mail, return receipt requested; or by overnight delivery;

(2) submit the communication electronically and maintain proof of the electronically submitted communication;

(3) if the entity accepts facsimile transmissions for the type of communication being sent, fax the communication and maintain proof of facsimile transmission; or

(4) hand deliver the communication and maintain a copy of the signed receipt acknowledging the hand delivery.

(c) If a communication is submitted by United States mail, first class, the communication is presumed to have been received on the fifth day after the date the communication is submitted, or, if the communication is submitted using overnight delivery service or United States mail return receipt requested, on the date the delivery receipt is signed.

(d) If a communication other than a claim is submitted electronically, the communication is presumed received on the date of submission. Communications electronically submitted after the receiving entity's normal business hours are presumed received the following business day.

(e) If a claim is submitted electronically, the claim is presumed received on the date of the electronic verification of receipt by the MCC or the MCC's clearinghouse. If the MCC's clearinghouse does not provide a confirmation of receipt of the claim or a rejection of the claim within 24 hours of submission by the physician, or the provider, or the physician's or provider's clearinghouse, the physician's or provider's clearinghouse must provide the confirmation. The physician's or provider's clearinghouse must be able to verify that the claim contained the correct payor identification of the entity to receive the claim.

(f) If a communication is faxed, the communication is presumed to have been received on the date of the transmission acknowledgement. Communications faxed after the receiving entity's normal business hours are presumed received the following business day.

(g) If a communication is hand delivered, the communication is presumed to have been delivered on the date the delivery receipt is signed.

(h) Any entity submitting a communication under subsection (b)(1) − (4) of this section may choose to maintain a mail log to provide proof of submission and establish date of receipt. The entity must fax or electronically transmit a copy of the mail log, if used, to the receiving entity at the time of the submission of a communication and include another copy with the relevant communication. The log must identify each separate claim, request for information, or response included in a batch communication. The mail log must include the following information: name of claimant; address of claimant; telephone number of claimant; claimant's federal tax identification number; name of addressee; name of MCC; designated address; date of mailing or hand delivery; subscriber name; subscriber ID number; patient name; date(s) of service or occurrence; delivery method; and claim number, if applicable.

§21.2817. Terms of Contracts. Unless otherwise provided in this subchapter, contracts between MCCs and preferred providers may not include terms that:

(1) extend the statutory or regulatory time frames; or

(2) waive the preferred provider's right to recover reasonable attorney's fees and court costs under Insurance Code §1301.108 and §843.343.

§21.2818. Overpayment of Claims.

(a) An MCC may recover a refund due to overpayment or completion of an audit if:

(1) the MCC notifies the physician or the provider of the overpayment not later than the 180th day after the date of receipt of the overpayment; or

(2) the MCC notifies the physician or the provider of the completion of an audit under §21.2809 of this title (relating to Audit Procedures).

(b) Notification under subsection (a) of this section must:

(1) be in written form and include the specific claims and amounts for which a refund is due, and for each claim, the basis and specific reasons for the request for refund;

(2) include notice of the physician's or provider's right to appeal; and

(3) describe the methods by which the MCC intends to recover the refund.

(c) A physician or a provider may appeal a request for refund by providing written notice of disagreement with the refund request not later than 45 days after receipt of notice described in subsection (a) of this section. On receipt of written notice under this subsection, the MCC must begin the appeal process provided for in the MCC's contract with the physician or the provider.

(d) An MCC may not recover a refund under this section until:

(1) for overpayments, the later of the 45th day after notification under subsection (a)(1) of this section or the exhaustion of any physician or provider appeal

rights under subsection (c) of this section, where the physician or the provider has not made arrangements for payment with an MCC; or

(2) for audits, the later of the 30th day after notification under subsection (a)(2) of this section or the exhaustion of any physician or provider appeal rights under subsection (c) of this section, where the physician or the provider has not made arrangements for payment with an MCC.

(e) If an MCC is a secondary payor and pays a portion of a claim that should have been paid by the MCC that is the primary payor, the secondary payor may only recover overpayment from the MCC that is primarily responsible for that amount. If the portion of the claim overpaid by the secondary payor was also paid by the primary payor, the secondary payor may recover the amount of overpayment from the physician or the provider that received the payment under the procedures set out in this section.

(f) Subsections (a) − (e) of this section do not affect an MCC's ability to recover an overpayment in the case of fraud or a material misrepresentation by a physician or a provider.

§21.2819. Catastrophic Event.

(a) An MCC, a physician, or a provider must notify the department if, due to a catastrophic event, it is unable to meet the deadlines in §21.2804 of this title (relating to Requests for Additional Information from Treating Preferred Provider), §21.2806 of this title (relating to Claim Filing Deadline), §21.2807 of this title (relating to Effect of Filing a Clean Claim), §21.2808 of this title (relating to Effect of Filing a Deficient Claim), §21.2809 of this title (relating to Audit Procedures), and §21.2815 of this title (relating to

Failure to Meet the Statutory Claims Payment Period), as applicable. The entity must send the notification required under this subsection to the department within five days of the catastrophic event.

(b) Within 10 days after the entity returns to normal business operations, the entity must send a certification of the catastrophic event to the Life/Health and HMO Intake Team, Texas Department of Insurance, P.O. Box 149104, Mail Code 106-1E, Austin, Texas 78714-9104. The certification must:

(1) be in the form of a sworn affidavit from:

(A) for a physician or a provider, the physician, the provider, the office manager, the administrator, or their designees; or

(B) for an MCC, a corporate officer or a corporate officer's designee;

(2) identify the specific nature and date of the catastrophic event; and

(3) identify the length of time the catastrophic event caused an interruption in the claims submission or processing activities of the physician, the provider, or the MCC.

(c) A valid certification to the occurrence of a catastrophic event under this section tolls the applicable deadlines in §§21.2804, 21.2806, 21.2807, 21.2808, 21.2809, and 21.2815 of this title for the number of days identified in subsection (b)(3) of this section as of the date of the catastrophic event.

§21.2820. Identification Cards.

(a) An identification card, or other similar document that includes information necessary to allow enrollees and insureds to access services or coverage under an HMO evidence of coverage, a preferred provider benefit plan, or an exclusive provider benefit plan that is issued by an MCC subject to this subchapter must comply with the requirements of this section.

(b) An identification card or other similar document issued to enrollees or to insureds must include the following information:

(1) the name of the enrollee or the insured;

(2) the first date on which the enrollee or the insured became eligible for benefits under the plan or a toll-free number that a preferred provider may use to obtain such information;

(3) for an exclusive provider benefit plan, the acronym “EPO” or the phrase “Exclusive Provider Organization”; and

(4) the letters “TDI” or “DOI” prominently displayed on the front of the card or the document.

§21.2821. Reporting Requirements.

(a) An MCC must submit to the department quarterly claims payment information in compliance with the requirements of this section.

(b) The MCC must submit the report required by subsection (a) of this section to the department on or before:

(1) May 15th for the months of January, February, and March of each year;

(2) August 15th for the months of April, May, and June of each year;

(3) November 15th for the months of July, August, and September of each year; and

(4) February 15th for the months of October, November, and December of each preceding calendar year.

(c) The report required by subsection (a) of this section must include, at a minimum, the following information:

(1) number of claims received from noninstitutional preferred providers;

(2) number of claims received from institutional preferred providers;

(3) number of clean claims received from noninstitutional preferred providers;

(4) number of clean claims received from institutional preferred providers;

(5) number of clean claims from noninstitutional preferred providers paid within the applicable statutory claims payment period;

(6) number of clean claims from noninstitutional preferred providers paid on or before the 45th day after the end of the applicable statutory claims payment period;

(7) number of clean claims from institutional preferred providers paid on or before the 45th day after the end of the applicable statutory claims payment period;

(8) number of clean claims from noninstitutional preferred providers paid on or after the 46th day and before the 91st day after the end of the applicable statutory claims payment period;

(9) number of clean claims from institutional preferred providers paid on or after the 46th day and before the 91st day after the end of the applicable statutory claims payment period;

(10) number of clean claims from noninstitutional preferred providers paid on or after the 91st day after the end of the applicable statutory claims payment period;

(11) number of clean claims from institutional preferred providers paid on or after the 91st day after the end of the applicable statutory claims payment period;

(12) number of clean claims from institutional preferred providers paid within the applicable statutory claims payment period;

(13) number of claims paid under the provisions of §21.2809 of this title (relating to Audit Procedures);

(14) number of requests for verification received under §19.1719 of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans);

(15) number of verifications issued under §19.1719 of this title;

(16) number of declinations of requests for verifications, under §19.1719 of this title;

(17) number of certifications of catastrophic events sent to the department;

(18) number of calendar days business was interrupted for each corresponding catastrophic event;

(19) number of electronically submitted, affirmatively adjudicated pharmacy claims received by the MCC;

(20) number of electronically submitted, affirmatively adjudicated pharmacy claims paid within the 18-day statutory claims payment period;

(21) number of electronically submitted, affirmatively adjudicated pharmacy claims paid on or before the 45th day after the end of the 18-day statutory claims payment period;

(22) number of electronically submitted, affirmatively adjudicated pharmacy claims paid on or after the 46th day and before the 91st day after the end of the 18-day statutory claims payment period; and

(23) number of electronically submitted, affirmatively adjudicated pharmacy claims paid on or after the 91st day after the end of the 18-day statutory claims payment period.

(d) An MCC must annually submit to the department, on or before August 15th, at a minimum, information related to the number of declinations of requests for verifications from July 1st of the prior year to June 30th of the current year, in the following categories:

(1) policy or contract limitations:

(A) premium payment time frames that prevent verifying eligibility for a 30-day period;

(B) policy deductible, specific benefit limitations, or annual benefit maximum;

(C) benefit exclusions;

(D) no coverage or change in membership eligibility, including individuals not eligible, not yet effective, or for whom membership is canceled;

(E) preexisting condition limitations; and

(F) other;

(2) declinations due to an inability to obtain necessary information to verify requested services from the following persons:

(A) the requesting physician or provider;

(B) any other physician or provider; and

(C) any other person.

§21.2822. Administrative Penalties.

(a) An MCC that fails to comply with §21.2807 of this title (relating to Effect of Filing a Clean Claim) for more than 2 percent of clean claims submitted to the MCC is subject to an administrative penalty under Insurance Code §843.342(k) or §1301.137(k), as applicable.

(b) The percentage of the MCC's compliance with §21.2807 of this title must be determined on a quarterly basis and must be separated into a compliance percentage for noninstitutional preferred provider claims and institutional preferred provider claims. Claims paid in compliance with §21.2809 of this title (relating to Audit Procedures) are not included in calculating the compliance percentage under this section.

§21.2823. Applicability to Certain Noncontracting Physicians and Providers. The provisions of §19.1719 of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans) and §21.2807 of this title (relating

to Effect of Filing a Clean Claim) apply to a physician or a provider that provides to an enrollee or an insured of an MCC:

(1) care related to an emergency or its attendant episode of care as required by state or federal law; or

(2) specialty or other medical care or health care services at the request of the MCC, the physician, or the provider because the services are not reasonably available from a physician or a provider who is included in the MCC's network.

§21.2824. Applicability. The amendments to §§21.2801 – 21.2803, 21.2807 – 21.2809, and 21.2811 – 21.2817 of this title (relating to Scope, Definitions, Elements of a Clean Claim, Effect of Filing a Clean Claim, Effect of Filing Deficient Claim, Audit Procedures, Disclosure of Processing Procedures, Denial of Clean Claim Prohibited for Change of Address, Requirements Applicable to Other Contracting Entities, Electronic Adjudication of Prescription Benefits, Failure to Meet the Statutory Claims Payment Period, Date of Receipt, and Terms of Contracts), and new §§21.2804 – 21.2806, 21.2818, 21.2819, and 21.2821 – 21.2825 of this title (relating to Requests for Additional Information from Treating Preferred Provider, Requests for Additional Information from Other Sources, Claims Filing Deadline, Overpayment of Claims, Catastrophic Event, Reporting Requirements, Administrative Penalties, Applicability to Certain Non-Contracting Physicians and Providers, Applicability, and Severability) apply to services provided, or inpatient services beginning, under contracts entered into or renewed between an MCC and a preferred provider after October 4, 2003, and to

services provided or hospital confinements beginning after October 4, 2003, by physicians and providers that do not have a contract with an MCC.

§21.2825. Severability. If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are severable.

§21.2826. Waiver. In compliance with Insurance Code §1211.001, the provisions in Insurance Code Chapter 1301, §1301.069, §1301.162, and Subchapters C and C-1; Chapter 1213; Chapter 843, §843.209, §843.319, and Subchapter J; as well as this subchapter and §§3.3703(a)(20), 11.901(a)(11), 19.1718, and 19.1719 of this title (relating to Contracting Requirements, Required Provisions, Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans, and Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans, respectively) are not applicable to Medicaid and Children's Health Insurance Program plans provided by an MCC to persons enrolled in the medical assistance program established under Human Resources Code Chapter 32 or the child health plan established under Health and Safety Code Chapter 62.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on January 23, 2014.

Sara Waitt
General Counsel
Texas Department of Insurance

The commissioner adopts amendments to §§21.2801 – 21.2809 and §§21.2811 – 21.2826.

Julia Rathgeber
Commissioner of Insurance

COMMISSIONER'S ORDER NO. **2968**