SUBCHAPTER T. Submission of Clean Claims
28 TAC §§21.2801 – 21.2809 and
§§21.2811 – 21.2826

1. INTRODUCTION. The Texas Department of Insurance (department) proposes amendments to 28 Texas Administrative Code (Administrative Code) Chapter 21, Subchapter T §§21.2801 – 21.2809 and §§21.2811 – 21.2826, concerning the elements and the processing of a clean health care claim.

The National Uniform Claims Committee (NUCC), the National Uniform Billing Committee (NUBC), and the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services (CMS) have identified much of the information needed to process a health care claim. Texas Insurance Code (Insurance Code) §1204.102 requires a provider to use one of two forms, HCFA 1500 or UB-82/HCFA, or their successor forms, for submission of certain claims. These proposed amendments are needed to allow a 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.

On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised CMS-1500 (02/12) claim form. On June 27, 2013, CMS announced its tentative timeline for implementing the form for submission of Medicare claims. On August 6, 2013, NUCC announced it had approved a transition timeline for use of the form for submission of non-Medicare claims. The transition timeline permits

use of the new form for non-Medicare claims beginning January 6, 2014, with mandatory use by April 1, 2014. These rules are being proposed and will be adopted on an expedited basis so that all affected parties can phase in their use of the new form before its mandatory use date.

House Bill 1772, 82nd Legislature, Regular Session (2011) amended Insurance Code Chapter 1301, Section 1301.0041 to add exclusive provider benefit plans to the entities regulated by the chapter. Under Administrative Code §3.3701, a provision that applies to a preferred provider benefit plan in the Administrative Code also applies to an exclusive provider benefit plan. The proposed 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 this proposal and throughout the proposed 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 Chapter 843, Section 843.339, and Chapter 1301, Section 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 proposed amendments are needed to incorporate those timelines into these rules.

The proposed amendments do not establish clean claim data elements for

pharmacy claims because Insurance Code §§843.339 and 1301.104, which establish the payment deadlines for such claims, reference the date a claim is affirmatively adjudicated, rather than the receipt of a clean claim.

House Bill 2064, 81st Legislature, Regular Session (2009) amended Insurance Code Chapter 843, Section 843.342, and Chapter 1301, Section 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 Risk Pool (Pool). The proposed 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 upon the Pool's dissolution. The proposed amendments are needed to add that reallocation to the rule.

Throughout the proposed 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 make the rules easier to read, understand, and use. These proposed nonsubstantive amendments will be noted in the explanatory text below, but will not be described in detail.

2. BRIEF EXPLANATION OF THE PROPOSED AMENDMENTS.

§21.2801. Purpose and Scope. The proposed amendment to §21.2801 reflects the

recodification of repealed Insurance Code Article 3.70-3C as Chapter 1301. The amendment also adds exclusive provider carriers to the entities governed by the rules, but excludes from the rule's coverage an exclusive provider benefit plan regulated under Chapter 3, Subchapter KK (Exclusive Provider Benefit Plan) of this title, that provides services under the Texas Children's Health Insurance Program or with the Statewide Rural Healthcare Program.

§21.2802. Definitions. Throughout this section, the rule substitutes the term "managed care carrier" (MCC) for the phrase "HMO or preferred provider carrier" to more easily identify the three types of entities governed by this subchapter (HMO, preferred provider carrier, and exclusive provider carrier). There are also nonsubstantive amendments made throughout the section to conform its language 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 make the rules easier to read, understand, and use. All other amendments are described below.

§21.2802(2), (4), (7), (9), (11), (13), (14), (15), (18), (21), (27), and (28) (Batch submission; CMS; Condition code; Corrected claim; Diagnosis code; HMO; HMO delivery network; Institutional provider; Patient control number; Physician; Provider; and Revenue code). These definitions are either unchanged or are amended only to update their paragraph number.

§21.2802(3), (5), (10), (16), (17), (19), (20), (22), (26), and (33) (Billed charges;

Catastrophic event; Deficient claim; NPI number; Occurrence span code; Patient financial responsibility; Patient-status-at-discharge code; Place of service code; Procedure code; and Type of bill code). These definitions are amended only to make minor language, punctuation, and grammatical changes intended to make the rules easier to read, understand, and use.

§21.2802(1) Audit. This definition is amended to introduce the term “managed care carrier” (MCC) to replace the rule’s existing language of “HMO or preferred provider carrier.”

Existing §21.2802(8), (12), (26), and (32) (Contracted rate; Duplicate claim; Procedure code; and Subscriber). These definitions are amended to substitute “MCC” for “HMO or preferred provider carrier” because they now also apply to exclusive provider carriers.

Proposed §21.2802(13) Exclusive provider carrier. The amended rule adds a definition of "exclusive provider carrier" because Insurance Code Chapter 1301 and these rules now apply to exclusive provider plans as set forth in Insurance Code §§1301.0041 and 1301.0042.

Proposed §21.2802(17) MCC or managed care carrier. The amended rule creates the term “managed care carrier” (MCC) to more easily identify the three types of entities governed by Subchapter T (HMO, preferred provider carrier, and exclusive provider carrier). The term “MCC” is then substituted for the phrase "HMO or

preferred provider carrier" throughout the balance of the rule.

Existing §21.2802(23) Preferred provider. The definition is amended to reflect that the term includes providers in both preferred provider plans and exclusive provider plans. Paragraph numbers are removed from two cites to Insurance Code §843.002 (*Definitions*) so that, should the statute's definitions change, the rule need not be amended to reflect a renumbering of those paragraphs.

Existing §21.2802(24) Preferred provider carrier. The definition is amended to reflect that the term does not include a carrier that issues exclusive provider benefit plans.

Existing §21.2802(25) Primary plan. The definition is amended to add language anticipating a successor rule to existing 28 TAC Chapter 3, Subchapter V, §§3.3501 − 3.3511 (Group Coordination of Benefits), because such a successor rule is now being drafted.

Existing §21.2802(29) Secondary plan. The definition is amended to add language anticipating a successor rule to existing 28 TAC Chapter 3, Subchapter V, §§3.3501 − 3.3511 (Group Coordination of Benefits), because such a successor rule is now being drafted.

Existing §21.2802(30) Source of admission code. The definition has been renamed *Point of Origin for Admission or Visit* to conform with the language of the new CMS-1500 (02/12) form. The definition is also amended to conform the section to the current language of the Administrative Code, and to make the rules easier to read,

understand, and use.

Existing §21.2802(31) Statutory claims payment period. The definition 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). It is also amended to add the payment periods that apply to electronically and nonelectronically submitted claims for prescription benefits.

§21.2803. Elements of a Clean Claim. Throughout this section, the rule substitutes the term “managed care carrier” (MCC) for the phrase "HMO or preferred provider carrier" to more easily identify the three types of entities governed by Subchapter T (HMO, preferred provider carrier, and exclusive provider carrier). The section also contains nonsubstantive amendments made to conform the section 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 make the rules easier to read, understand, and use. All other amendments are described below.

§21.2803(a). Filing a Clean Claim. The proposed amendments to §21.2803(a) are meant to make it easier to locate the requirements for submission of nonelectronic dental claims, and electronic claims (including electronic dental claims submitted to an HMO).

§21.2803(b). Required data elements. In order to conform the rule’s standards with those of CMS, the amendments to §21.2803(b) adopt 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. There are also nonsubstantive amendments to the section.

§21.2803(b)(1). Successor form CMS-1500 (02/12) introduced. This paragraph introduces successor form CMS-1500 (02/12) and addresses its phase-in period.

Most of the data element requirements in proposed §21.2803(b)(1) are identical to those required on predecessor form CMS-1500 (08/05); all variances are described below. There are also nonsubstantive amendments throughout this paragraph, such as the redesignating of subparagraphs because the new form does not collect some of the information required by the existing form.

The data element requirements for form CMS-1500 (08/05), now found in existing §21.2803(b)(1), apply to any claims filed before the transition to form CMS-1500 (02/12). The data element requirements for form CMS-1500 (08/05) will be found in the proposed rule in §21.2803(b)(2). There are nonsubstantive amendments throughout paragraph (2) to conform the paragraph 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 make the rules easier to read, understand, and use.

Existing §21.2803(b)(1)(J) and (K) (other insured's date of birth; other insured's plan name). Proposed paragraph (b)(1) does not include subparagraphs (J) and (K) of

the existing rule because superseding form CMS-1500 (02/12) does not collect the information captured by form CMS-1500 (08/05) in those subparagraphs.

Existing §21.2803(b)(1)(N) (duplicate claim). The amended rule does not include existing subparagraph (N), addressing field 10d, because new form CMS-1500 (02/12) collects that information in field 30 in proposed subparagraph (HH).

Existing §21.2803(b)(1)(W) (NPI number of referring physician). Existing subparagraph (W) specifically addresses claims filed or refiled on or after May 23, 2008. That language is not included in corresponding proposed subparagraph (T) because it will no longer be necessary.

Existing §21.2803(b)(1)(X) (narrative description of procedure). The substance of existing subparagraph (X), CMS-1500 (08/05), field 19 will be captured in proposed subparagraph (Y), which will address CMS-1500 (02/12), field 24D. Form CMS-1500 (02/12) identifies field 19 as "Additional Claim Information." The information in existing subparagraph (CC), which addresses field 24D, is also captured in proposed subparagraph (Y).

Existing §21.2803(b)(1)(Y) (diagnosis codes). Existing subparagraph (Y), addressing CMS-1500 (08/05), field 21 requires that the primary diagnosis code be entered first, and allows up to four diagnosis codes. In proposed redesignated subparagraph (U), form CMS-1500 (02/12), field 21 will require the physician or provider to identify which version of the ICD codes (ICD-9-CM or ICD-10-CM) is used,

and will allow up to twelve diagnosis codes.

Existing §21.2803(b)(1)(Z) (verification number). The data element now required in CMS-1500 (08/05), field 23 will be captured in proposed subparagraph (V) (CMS-1500 (02/12), field 23 (*prior authorization number*). Proposed subparagraph (V) will also reflect the recent amendment of the Utilization Review Rule (28 TAC §§19.1701-19.1719), effective February 20, 2013, which redesignated §19.1724 as §19.1719.

Existing §21.2803(b)(1)(CC) (procedure/modifier code). This data element will be captured in proposed subparagraph (Y). Proposed subparagraph (Y) will also capture the information now collected in existing subparagraph (X) (*narrative description of procedure*).

Existing §21.2803(b)(1)(GG) (NPI number of rendering physician or provider). The language in existing subparagraph (GG) on claims filed or refiled on or after May 23, 2008, CMS-1500 (08/05), field 24J is not included in proposed corresponding subparagraph (CC) (CMS-1500 (02/12), field 24J) because it is no longer necessary.

Proposed §21.2803(b)(1)(HH) (duplicate claim). Proposed subparagraph (HH) will collect in CMS-1500 (02/12), field 30 the information now collected in subparagraph (N) (CMS-1500 (08/05), field 10d).

Existing §21.2803(b)(1)(NN) and (PP) (NPI numbers). The dates shown in these subparagraphs will not be included in the correlating proposed subparagraphs (KK) and (MM) because they are no longer relevant.

Existing §21.2803(b)(2). Redesignation of predecessor form CMS-1500 (08/05); elimination of obsolete form CMS-1500 (12/90). The rule is amended to delete the text of existing paragraph §21.2803(b)(2) in order 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). New paragraph §21.2803(b)(2) specifies that physicians and noninstitutional providers filing or refiling nonelectronic claims 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.

There are nonsubstantive amendments throughout §21.2803(b)(2) to conform the paragraph to the current codification and language of the Insurance and Administrative Codes, to update internal references, and to make minor language, punctuation, and grammatical changes to make the rules easier to read, understand, and use.

§21.2803(b)(3). Claim form UB-04. The proposed amendments to this paragraph eliminate timeframes that are no longer relevant because the UB-04 claim form is currently the only form institutional providers may use.

§21.2803(b)(4). Predecessor claim form UB-92. The proposed amended rules delete this paragraph because the UB-92 claim form is no longer in use.

§21.2803(c). Required data elements for dental claims. All amendments to this paragraph are nonsubstantive; they make minor language, punctuation, and grammatical changes to make the rule easier to read, understand, and use.

§21.2803(d). Coordination of benefits. Subsection (d) has been divided into three paragraphs to make it easier to read and understand. It is also amended to incorporate CMS-1500 (02/12) and to delete obsolete forms CMS-1500 (12/90) and UB-92. Language has been added to allow for coordination between this section and any successor rule to existing 28 TAC Chapter 3, Subchapter V, §§3.3501 − 3.3511 (Group Coordination of Benefits), because such a successor rule is now being drafted. The remaining amendments update internal references, and make minor language, punctuation, and grammatical changes to make the rule easier to read, understand, and use.

§21.2803(e). Submission of electronic clean claim. The amendments to this subsection make minor language changes to make the rule easier to read, understand, and use.

§21.2803(f). Coordination of benefits on electronic clean claims. Language has been added to allow for coordination between this section and any successor rule to existing 28 TAC Chapter 3, Subchapter V, §§3.3501 − 3.3511 (Group Coordination of Benefits), because such a successor rule is now being drafted. The remaining amendments conform the subchapter to the current language of the Insurance and Administrative Codes, make minor language, punctuation, and grammatical changes

to make the rule easier to read, understand, and use.

§21.2803(g). Format of elements. Amendments to this subsection update internal references, and make minor language, punctuation, and grammatical changes to conform the subchapter to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

§21.2803(h). Additional data elements or information. The one amendment to this subsection makes a minor language change to conform the subchapter to the current language of the Insurance and Administrative Codes.

§21.2804. Requests for Additional Information from Treating Preferred Provider. The amendments to this section substitute the term “managed care carrier” (MCC) for the phrase "HMO or preferred provider carrier," and make nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

§21.2805. Requests for Additional Information from Other Sources. The amendments to this section substitute the term “managed care carrier” (MCC) for the phrase "HMO or preferred provider carrier," and make nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

§21.2806. Claims Filing Deadline. The rule amends the section’s title to correct its

grammar. It adds subsection headings to conform to the Administrative Code's current custom. The rule also substitutes the term "managed care carrier" (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use. All other amendments are described below.

§21.2806(c) Manner of claim submission. The rule corrects the subsection by including a method of claim submission listed in §21.2816 that had been omitted.

§21.2806(e) Duplicate claims. The proposed rule divides this subsection into three paragraphs to reflect that prescription benefit claims are subject to different statutory claims payment periods, and makes nonsubstantive changes to make the subsection easier to read, understand, and use.

§21.2807. Effect of Filing a Clean Claim. The rule amends this section to substitute the term "managed care carrier" (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use. All other amendments are described below.

§21.2807(c). The proposed rule will eliminate this subsection about claims for prescription benefits because, as noted in the Introduction, Insurance Code §§843.339 and 1301.104, which establish the deadlines for action on prescription claims, reference the date such claims are affirmatively adjudicated, rather than their receipt as a clean

claim.

§21.2808. Effect of Filing Deficient Claim. The rule substitutes the term “managed care carrier” (MCC) for the phrase “HMO or preferred provider carrier,” and makes nonsubstantive minor language, punctuation, and grammatical changes, including to the section’s title, to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

The rule also reflects the new statutory time limits that apply to prescription benefit claims.

§21.2809. Audit Procedures. The rule adds subsection headings to conform to the Administrative Code’s current custom. The rule also substitutes the term “managed care carrier” (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, to update the rule’s internal references, and to make the rule easier to read, understand, and use. All other amendments are described below.

§21.2809(a). *Notice and payment required.* The amended rule corrects an error in the existing text of this subsection. The rule also breaks this subsection into two parts.

Proposed §21.2809(b). Failure to provide notice and payment. This added subsection corrects the rule’s existing text: it completes a subsection’s heading, 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.

§21.2811. Disclosure of Processing Procedures. The rule substitutes the term "managed care carrier" (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

§21.2812. Denial of Clean Claim Prohibited for Change of Address. The rule substitutes the term "managed care carrier" (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

§21.2813. Requirements Applicable to Other Contracting Entities. The rule substitutes the term "managed care carrier" (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

§21.2814. Electronic Adjudication of Prescription Benefits. The rule substitutes the term "managed care carrier" (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes,

and to make the rule easier to read, understand, and use. The section also deletes from its title and text references to electronic claims, because it is now applicable to all claims for prescription benefits.

§21.2815. Failure to Meet the Statutory Claims Payment Period. The rule amends this section to conform it with Insurance Code Chapter 843, Section 843.342 (Violation of Certain Claims Payment Provisions; Penalties), and Chapter 1301, Section 1301.137 (Violation of Claims Payment Requirements; Penalty). These Insurance Code sections were amended in 2009 to establish different penalties and interest for late payment and underpayment of clean claims to institutional and noninstitutional providers, for an MCC's late payment or underpayment of a clean claim.

Senate Bill 1367, passed in the most recent regular legislative session, reallocated payments made to the Pool under the clean claims rules to the department upon the Pool's dissolution. The proposed rule includes that reallocation.

The rule also substitutes the term "managed care carrier" (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

§21.2816. Date of Receipt. The rule substitutes the term "managed care carrier" (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the

current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

§21.2817. Terms of Contracts. The rule substitutes the term “managed care carrier” (MCC) for the phrase “HMO or preferred provider carrier,” and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

§21.2818. Overpayment of Claims. The rule substitutes the term “managed care carrier” (MCC) for the phrase “HMO or preferred provider carrier,” and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

The rule also corrects the title cited for §21.2809 from “Audits” to “Audit Procedures.”

§21.2819. Catastrophic Event. The rule substitutes the term “managed care carrier” (MCC) for the phrase “HMO or preferred provider carrier,” and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

The rule also corrects the address to which an MCC must send notice of a catastrophic event, and corrects the titles cited for several sections within the rule.

§21.2820. Identification Cards. The rule substitutes the term “managed care carrier” (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

The rule adds to this section the statutory requirements for exclusive provider plans, which are not identical to those for HMOs and preferred provider plans.

The rule deletes subsection (c), establishing effective dates for that section, as those dates are now obsolete.

§21.2821. Reporting Requirements. The rule substitutes the term “managed care carrier” (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

The rule deletes the text of subsection (c) because it is obsolete. The rule changes citations to reflect revisions to 28 TAC Chapter 19 (Agents’ Licensing). The rule also captures the new statutory timeline for payment of electronic pharmacy claims.

The rule amends citations to reflect revisions to 28 TAC Chapter 19 (Agents’ Licensing).

§21.2822. Administrative Penalties. The rule substitutes the term “managed care carrier” (MCC) for the phrase "HMO or preferred provider carrier," and makes

nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

§21.2823. Applicability to Certain Non-contracting Physicians and Providers. The rule substitutes the term “managed care carrier” (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes, including to the section’s title, to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

The rule amends citations to reflect revisions to 28 TAC Chapter 19 (Agents’ Licensing).

§21.2824. Applicability. The rule substitutes the term “managed care carrier” (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

§21.2825. Severability. The rule amends this section to clarify the scope of its severability, and to conform with current state law on severability.

§21.2826. Waiver. This section adds Insurance Code §1211.001 (Waiver of Certain Provisions for Certain Federal Health Plans) as statutory authority for waiving statutory

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

The rule amends citations to reflect revisions to both the Insurance and Administrative Codes, deletes repealed provisions, and includes as waived the following provisions: Insurance Code Chapter 1301, §1301.069 (Services Provided by Certain Physicians and Health Care Providers), §1301.162 (Identification Card), Subchapter C (Prompt Payment of Claims) and C-1 (Other Provisions Relating to Payment of Claims), Chapter 1213 (Electronic Health Care Transactions), Chapter 843, §843.209 (Identification Card) and §843.319 (Certain Required Contracts), and Subchapter J (Payment of Claims to Physicians and Providers); and Administrative Code Chapter 21, Subchapter T (Submission of Clean Claims), Chapter 3, §3.3703(a)(20) (Contracting Requirements), and Chapter 11, §11.901(a)(11) (Required Provisions).

The rule also substitutes the term “managed care carrier” (MCC) for the phrase "HMO or preferred provider carrier," and makes nonsubstantive minor language, punctuation, and grammatical changes to conform the section to the current language of the Insurance and Administrative Codes, and to make the rule easier to read, understand, and use.

3. FISCAL NOTE. Katrina Daniel, associate commissioner for the Life, Accident, and Health Section, has determined that for each year of the first five years the proposed amendments will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of this proposal. There may be start-up costs for reprogramming billing systems to local governmental units

that file health care claims, including electronic pharmacy claims, subject to statutory requirements in Insurance Code §§843.336, 843.339, 1204.102, 1301.104, and 1301.131, requiring that physicians and providers use specified uniform billing forms and successor forms. These costs are the result of these statutory requirements and not the result of the adoption, administration, or enforcement of the rule amendments. The amendments included in this proposal are necessary because the NUCC and CMS are implementing a new form and discontinuing the form required in Insurance Code §§843.336, 1204.102, and 1301.131 and in current 28 TAC §21.2803(b)(1). There will be no measurable effect on local employment or the local economy as a result of the proposal.

4. PUBLIC BENEFIT/COST NOTE. Associate Commissioner Daniel has also determined that for each year of the first five years the amendments are in effect, there will be a public benefit from increased consistency between standard and nonstandard health care transactions, and from continued streamlining and standardization of the nonelectronic claims filing and payment process. The resulting increase in efficiency will benefit managed care carriers, physicians, providers, insureds, and enrollees.

Proposed amendments to data elements for the successor form are nonsubstantive and so will not result in any new economic cost to physicians, providers, or managed care carriers.

The probable economic cost to persons required to comply with the amendments establishing data element requirements for the new form results from the

statutory requirements of Insurance Code §§843.336, 1204.102, and 1301.131 that physicians and providers use specified uniform claim billing forms and successor forms, and not from the adoption, administration, or enforcement of the amendments. NUCC's and CMS's implementation of a new form and discontinuation of the previous form make these proposed amendments necessary.

The proposed amendments also increase clarity and consistency by updating the existing rules to reflect legislation on electronic pharmacy claim payment timelines, on exclusive provider benefit plans, on allocation of certain penalties for late- and underpayment of claims to the Pool, and the reallocation of those penalties to the department on the Pool's dissolution. Because the proposed amendments incorporate, but do not expand, the requirements of statutes already in effect, the amendments themselves should not create additional cost.

Although any increased costs are caused by the legislative requirements implemented by the proposed amendments, rather than by the amendments themselves, staff provides the following information relevant to implementation costs for affected parties. Estimated personnel costs for reprogramming billing systems and claims processing systems for compliance with the proposed amendments are based on data from the U.S. Department of Labor, Bureau of Labor Statistics, as reported in the survey, *Occupational Employment and Wages, May 2012,* which indicates that the mean hourly wage for a computer programmer employed by an insurance carrier is $36.78, and the mean hourly wage for a computer programmer in general is $37.63. The amount of time necessary to reprogram a provider's billing system or a

managed care carrier's claim processing system will vary based on the needs of the subject, but the resulting standardization should preclude any increased administrative costs that would otherwise result from billing and processing in the absence of a standardized data element set. The amount of time necessary to implement the systems changes will also vary based on the needs of the subject, but the department notes that the NUCC and CMS have undertaken educational efforts associated with implementation of the successor form over the last year, putting physicians, providers, and managed care carriers on notice of pending changes. The department anticipates that these educational efforts have resulted in early implementation planning by some carriers and providers, reducing the time required to implement necessary changes, reducing costs associated with implementation, and generally minimizing the burden to the affected parties. The department anticipates that physicians and providers, and managed care carriers will be able to implement the changes in compliance with the proposed timelines.

5. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. Government Code §2006.002(c) requires that if a proposed rule may have an economic impact on small businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small businesses and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. Government Code §2006.001(2) defines "small business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for

the purpose of making a profit, is independently owned and operated, and has fewer than 100 employees or less than $6 million in annual gross receipts. Government Code §2006.001(1) defines "micro business" similarly to "small business" but specifies that such a business may not have more than 20 employees. Government Code §2006.002(f) requires a state agency to adopt provisions concerning micro businesses that are uniform with those provisions outlined in Government Code §2006.002(b) - (d) for small businesses.

The effect on small and micro-businesses should be the same as that for the larger entities. As already stated, the costs associated with compliance with the proposed amendments will vary based on the individual needs of the subject, but the mean hourly rate for a computer programmer should be substantially the same regardless of whether the subject is a small, micro-, or large business. It is neither legal nor feasible to waive the requirements of the section for small or micro-businesses as contemplated by Government Code §2006.001. Insurance Code §1204.102 applies to all providers who seek payment or reimbursement under a health benefit plan and to all issuers of health benefit plans. The exemption of small or micro- businesses from the adoption of the proposed amendments or the adoption of separate compliance standards for small or micro- businesses would undermine the standardization of nonelectronic billing and claims payment processes achieved through the implementation of Insurance Code §§843.336, 1204.102, and 1301.131.

6. TAKINGS IMPACT ASSESSMENT. The department has determined that no private

real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action, and so does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

7. REQUEST FOR PUBLIC COMMENT. If you wish to comment on the proposal, you must do so in writing no later than 5 p.m. on Sunday, December 15, 2013. TDI requires two copies of your comments. Send one copy to Sara Waitt, general counsel, by email at: chiefclerk@tdi.texas.gov or by mail at Mail Code 113-2A, Texas Department of Insurance, Office of the Chief Clerk, P.O. Box 149104, Austin, Texas 78714-9104. Send the other copy to Patricia Brewer by email at: LHLcomments@tdi.texas.gov or by mail at: Mail Code 107-2A, Texas Department of Insurance, Regulatory Matters, P.O. Box 149104, Austin, Texas 78714-9104.

The commissioner will consider the adoption of the proposed amendments in a public hearing under Docket No. 2757 scheduled for December 12, 2013, at 9 a.m. in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. The commissioner will consider written and oral comments presented at the hearing.

8. STATUTORY AUTHORITY. TDI proposes the amended rule 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.

9. CROSS REFERENCE TO STATUTE. All statutes cited below are in the Insurance Code unless otherwise noted. The following statutes are affected by this proposal:

Rule	Statute
§21.2801	§§1301.0041, 1301.0042
§21.2802	§§1204.102, 1301.0041, 1301.0042, 1301.103, 1301.104, 1301.1054, 1301.131, 843.337, 843.338, 843.3385, 843.339, 843.349
§21.2803	§§1204.102, 1301.0041, 1301.0042, 1301.102, 1301.131, 843.336, 843.337

§21.2804	§§1301.0041, 1301.0042, 1301.1054, 843.3385
§21.2805	§§1301.0041, 1301.0042, 1301.1054, 843.3385
§21.2806	§§1301.0041, 1301.0042, 1301.102, 843.337
§21.2807	§§1301.0041, 1301.0042, 1301.103, 1301.104, 843.338, 843.339
§21.2808	§§1301.0041, 1301.0042
§21.2809	§§1301.0041, 1301.0042, 1301.105, 1301.1051, 1301.1052, 843.340
§21.2811	§§1301.0041, 1301.0042, 1301.007, 843.151
§21.2812	§§1301.0041, 1301.0042, 1301.007, 843.151
§21.2813	§§1301.0041, 1301.0042, 1301.109, 1301.138, 843.344
§21.2814	§§1301.0041, 1301.0042, 1301.007, 843.151
§21.2815	§§1301.0041, 1301.0042, 1301.137, 843.342, and SB 1367 (83rd Legislature, Regular Session)
§21.2816	§§1301.0041, 1301.0042, 1301.1021, 843.337
§21.2817	§§1301.0041, 1301.0042, 1301.107, 1301.108, 843.343, 843.353
§21.2818	§§1301.0041, 1301.0042, 1301.132, 1301.134, 843.349, 843.350
§21.2819	§§1301.0041, 1301.0042, 1301.102,

	843.337
§21.2820	§§1301.0041, 1301.0042, 1301.062, 1301.1581
§21.2821	§§1301.0041, 1301.0042, 1301.133, 1301.135, 1301.137, 843.342, 843.347, 843.348
§21.2822	§§1301.0041, 1301.0042, 1301.137, 843.342
§21.2823	§§1301.0041, 1301.0042, 1301.069, 1301.133, 1301.135, 843.347, 843.348, 843.351
§21.2826	§1211.001

10. 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 [~~Article 3.70-3C (Preferred Provider Benefit Plans) and Chapter 843 of the Insurance Code~~] relating to clean claims and prompt payment of physician and provider claims. This subchapter applies to all nonelectronic [~~non-electronic~~] 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 [~~shall~~] 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) [~~an HMO or preferred provider carrier~~] may investigate a claim beyond the statutory claims payment period without incurring penalties under §21.2815 of this title (relating to Failure to Meet the Statutory Claims Payment Period).

(2) (No change.)

(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 [~~Texas~~] Health and Safety Code §311.0025, [~~Texas~~] Occupations Code §105.002, and [~~Texas~~] Insurance Code Chapter 552.

(4) (No change.)

(5) Catastrophic event--An event, including an act [~~acts~~] of God, civil or military authority, or [~~acts of~~] public enemy; [~~,~~] war, accident, fire, explosion, [~~accidents, fires, explosions,~~] earthquake, windstorm, flood, or organized labor stoppage, [~~stoppages,~~] that cannot reasonably be controlled or avoided and that causes an

interruption in the claims submission or processing activities of an entity for more than two consecutive business days.

(6) Clean claim--

(A) For nonelectronic [~~non-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 that includes:

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

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

(B) For electronic claims, a claim submitted by a physician or 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) (No change.)

(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 [~~HMO or preferred provider~~].

(9) (No change.)

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

(11) (No change.)

(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 [~~HMO or preferred provider carrier~~].

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

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

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

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

(17) MCC or managed care carrier--An HMO, a preferred provider carrier, or an exclusive provider carrier, except as otherwise prohibited under federal law.

(18) [~~(16)~~] NPI number--The National Provider Identifier standard unique

health identifier number for health care providers assigned under [~~pursuant to~~] 45 Code of Federal Regulations Part 162 Subpart D [~~,~~] or a successor rule.

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

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

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

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

(23) [~~(21)~~] Physician--Anyone licensed to practice medicine in this state.

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

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

(26) [~~(23)~~] 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

[~~(Definitions).~~]

(B) with regard to an HMO: [~~,~~]

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

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

(27) [~~(24)~~] Preferred provider carrier--An insurer that issues a preferred provider benefit plan as provided by Insurance Code Chapter 1301. The term does not include an insurer that issues an exclusive provider benefit plan as provided by Insurance Code Chapter 1301.

(28) [~~(25)~~] Primary plan--As defined in §3.3506 of this title (relating to Use of the Terms "Plan," "Primary Plan," "Secondary Plan," and "This Plan" in Policies, Certificates, and Contracts), or in a successor rule adopted by the commissioner.

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

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

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

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

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

(33) [~~(31)~~] Statutory claims payment period--

(A) the 45 calendar days during [~~45-calendar-day period in~~] which an MCC must [~~HMO or preferred provider carrier shall~~] pay or deny a claim [~~make claim payment or denial~~], in whole or in part, after receipt of a nonelectronic [~~non-electronic~~] clean claim under [~~pursuant to~~] 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 (relating to Catastrophic Event);

(B) the 30 calendar days [~~30-calendar-day period in~~] during which an MCC must [~~HMO or preferred provider carrier shall~~] pay or deny a claim [~~make claim payment or denial~~], in whole or in part, after receipt of an electronically submitted clean claim under [~~pursuant to~~] Insurance Code Chapters 843 and 1301, and any extended period permitted under §§21.2804 or 21.2819 of this title; [~~or~~]

(C) the 21 calendar days [~~21-calendar-day period in~~] during which an MCC [~~HMO or preferred provider carrier~~] must pay a claim [~~shall make claim payment~~] after affirmative adjudication of a [~~an electronically submitted clean~~] claim for

a prescription benefit that is not electronically submitted under [~~pursuant to~~] Insurance Code Chapters 843 and 1301 [~~,~~] and §21.2814 of this title (relating to [~~Electronic~~] 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.

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

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

§21.2803. Elements of a Clean Claim.

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

(1) for nonelectronic [~~non-electronic~~] claims other than dental claims, the required data elements specified in subsection (b) of this section; [~~,~~]

(2) [~~or~~] for nonelectronic [~~non-electronic~~] dental claims filed with an HMO, the required data elements specified in subsection (c) of this section;

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

(4) [~~(3)~~] if applicable, any coordination of benefits or nonduplication [~~non-duplication~~] of benefits information under [~~pursuant to~~] subsection (d) of this section.

(b) Required data elements. CMS has developed claim forms that [~~which~~] provide much of the information needed to process claims. Insurance Code Chapter 1204 identifies two of these forms, HCFA 1500 and UB-82/HCFA, and their successor forms, as required for the submission of certain claims. The terms in paragraphs (1) - (3) [~~(4)~~] of this subsection are based on [~~upon~~] the terms CMS used on successor forms CMS-1500 (02/12), CMS-1500 (08/05) [~~,CMS-1500 (12/90)~~], UB-04 CMS-1450, and (UB-04) [~~UB-92 CMS-1450~~]. 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 [~~re-filed~~] by physicians or noninstitutional providers are set forth in paragraphs (1) and (2) of this subsection. Mandatory form usage dates and optional form transition dates for nonelectronic claims filed or refiled [~~re-filed~~] by institutional providers are set forth in paragraph (3) [~~paragraphs (3) and (4)~~] 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, upon 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) prior to the mandatory use date described in this paragraph, subject to the required data elements set forth 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 upon 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 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) 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) 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;

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

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

(Y) 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;

(Z) 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;

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

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

(CC) 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;

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

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

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

(GG) 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;

(HH) 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 30);

(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 prior to June 17, 2003.

(2) [~~(1)~~] Required form and data elements for physicians or noninstitutional providers for claims filed or refiled [~~re-filed~~] before the later of April 1, 2014 [~~on or after the later of July 18, 2007~~], or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (02/12) claim form [~~CMS-1500 (08/05)~~] for Medicare claims. The CMS-1500 (08/05) claim form [~~CMS-1500 (12/90)~~] and the data elements described in this paragraph are required for claims filed or refiled [~~re-filed~~] by physicians or noninstitutional providers before the later of these two dates: April 1, 2014 [~~(July 18,2007)~~], or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (02/12) claim form [~~CMS-1500 (08/05)~~] for Medicare claims. The CMS-1500 (08/05) claim form [~~CMS-1500 (12/90)~~] must be completed in compliance [~~accordance~~] with the special instructions applicable to the data element as described in this paragraph for clean claims filed by physicians and noninstitutional providers. However, upon notification that an MCC [~~HMO or preferred provider carrier~~] is prepared to accept claims filed or refiled [~~re-filed~~] on form CMS-1500 (02/12) [~~CMS-1500 (08/05)~~], a physician or noninstitutional provider may submit claims on form CMS-1500 (02/12) [~~CMS-1500 (08/05)~~] prior to the subsection (b)(1) mandatory use date described in this paragraph, subject to the subsection (b)(1) required data elements set forth in the paragraph.

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

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

(C) patient's date of birth and sex [~~gender~~] (CMS-1500 (08/05),

field 3) is required;

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

(E) patient's address (street or P.O. Box, city, state, ZIP 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 [~~(1)(Q) of this subsection~~], "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 [~~policy/group~~] number (CMS-1500 (08/05), field 9a) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this

section. If the required data element specified in subparagraph (Q) of this paragraph [~~(1)(Q) of this subsection~~], "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 [~~(1)(Q) of this subsection~~], "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 [~~(1)(Q) of this subsection~~], "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 [~~(1)(Q) of this subsection~~], "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 [~~shall~~] enter "N" if the answer is "No" or if the information is not available;

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

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

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

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

(i) if answered "yes," then:

(I) data elements specified in subparagraphs (H) – (L) of this paragraph [~~(1)(H) - (L) of this subsection~~] 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 [~~(1)(H) - (L) of this subsection~~];

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

(ii) if answered "no," the data elements specified in subparagraphs (H) – (L) of this paragraph [~~(1)(H) - (L) of this subsection~~] 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 [~~shall~~] submit a copy of the signed document to the MCC [~~HMO or preferred provider carrier~~] upon 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 [~~shall~~] enter the name of the referring primary care physician, specialty physician, hospital, or other source (CMS-1500 (08/05), field 17); however, if there is no referral, the physician or the provider must [~~shall~~] 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 [~~shall~~] enter the ID Number of the referring primary care physician, specialty physician, or hospital (CMS-1500 (08/05), field 17a);

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

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

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

required, 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 [pursuant to] §19.1719 [§19.1724] 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) [for claims filed or re-filed on or after May 23, 2008,]the NPI number of the rendering physician or provider (CMS-1500 (08/05), field 24J, unshaded portion) is required if the rendering provider is not the billing provider listed in CMS-1500 (08/05), field 33, and if the rendering physician or provider is eligible for an NPI number;

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

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

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

(KK) amount paid (CMS-1500 (08/05), field 29) is required if an amount has been paid to the physician or 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 [~~in accordance~~] with subparagraph (Q) of this paragraph [~~(1)(P) of this subsection~~] 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 [~~HMO or preferred provider carrier~~] (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) [~~for claims filed or re-filed on or after May 23, 2008,~~] the NPI number of the facility where services were [~~are~~] 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) [~~for claims filed or re-filed on or after May 23, 2008,~~] 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 [~~HMO or preferred provider carrier~~] required provider numbers and gave notice of the requirement to physicians and providers prior to June 17, 2003.

[~~(2) Required form and data elements for physicians or noninstitutional providers for claims filed or re-filed before the later of July 18, 2007, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (08/05) for Medicare claims. The CMS-1500 (12/90) and the data elements described in this paragraph are required for claims filed or re-filed by physicians or noninstitutional providers before the later of these two dates: July 18, 2007, or the earliest compliance date required by CMS for mandatory use of the CMS-1500 (08/05) for Medicare claims. The CMS-1500 (12/90) must be completed in accordance with the special instructions applicable to the data element as described in this paragraph for clean claims filed by physicians and noninstitutional providers. However, upon notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on form CMS-1500 (08/05), a physician or noninstitutional provider may submit claims on form CMS-1500 (08/05) prior to the subsection (b)(1) mandatory use date, subject to the subsection (b)(1) required data elements.~~]

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

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

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

~~is required;~~]

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

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

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

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

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

[~~(I) other insured's or enrollee's policy/group number (CMS-1500 (12/90), field 9a) is required if the patient is covered by more than one health benefit plan, generally in situations described in subsection (d) of this section. If the required~~

~~data element specified in paragraph (2)(Q) of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;]~~

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

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

~~anesthesiologist with no direct patient contact, the physician or provider must either enter the information or enter "NA" (not available) if the information is unknown;]~~

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

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

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

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

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

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

[~~(i) if answered "yes", then:~~]

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

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

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

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

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

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

~~an accident;~~]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) provider’s name, address, and telephone number (UB-04, field 1) are [~~is~~] required;

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

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

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

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

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

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

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

(I) patient's 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 [~~e.g.,~~] emergency, urgent, elective, newborn) (UB-04, field 14) is required for admissions;

(M) point of origin for admission or visit code [~~source of admission code~~] (UB-04, field 15) is required;

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

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

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

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

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

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

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

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

(V) Healthcare Common Procedure Coding System (HCPCS) codes or rates [HCPCS/Rates](UB-04, field 44) are required if Medicare is a primary or secondary payor;

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

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

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

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

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

(BB) prior payments-payor (UB-04, field 54) are required if

payments have been made to the provider by a primary plan as required by subsection (d) of this section;

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

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

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

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

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

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

(II) verification number (UB-04, field 63) is required if services have been verified under [~~pursuant to~~] §19.1719 [~~§19.1724~~] of this title. If no verification has been provided, treatment authorization codes (UB-04, field 63) are required when authorization is required and granted;

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

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

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

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

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

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

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

[~~(4) Required form and data elements for institutional providers for claims filed or re-filed before July 18, 2007. The UB-92 CMS-1450 and the data elements described in this paragraph are required for claims filed or re-filed by institutional providers before July 18, 2007. The UB-92 CMS-1450 must be completed in accordance with the special instructions applicable to the data element as described in this paragraph for clean claims filed by institutional providers. However, upon notification that an HMO or preferred provider carrier will accept claims filed or re-filed on form UB-04 CMS-1450, an institutional provider may submit claims on form UB-04 CMS-1450 prior to the subsection (b)(3) mandatory use date, subject to the subsection~~

~~(b)(3) required data elements.~~]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[~~(GG) prior payments-payor and patient (UB-92, field 54) are required if payments have been made to the physician or provider by the patient or another payor or subscriber, on behalf of the patient or subscriber, or by a primary plan as required by subsection (d) of this section;~~]

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

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

[~~(JJ) patient's/subscriber's certificate number, health claim number,~~

~~ID number (UB-92, field 60) is required if shown on the patient's ID card;~~]

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

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

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

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

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

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

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

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

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

[~~(TT) signature of provider representative, electronic signature or notation that the signature is on file with the HMO or preferred provider carrier (UB-92,~~

~~field 85) is required; and~~]

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

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

(1) patient's [~~Patient's~~] name is required;

(2) patient's [~~Patient's~~] address is required;

(3) patient's [~~Patient's~~] date of birth is required;

(4) patient's [~~Patient's~~] sex [~~gender~~] is required;

(5) patient's [~~Patient's~~] relationship to subscriber is required;

(6) subscriber's [~~Subscriber's~~] name is required;

(7) subscriber's [~~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 [~~Subscriber's~~] date of birth is required, if shown on the patient's ID card;

(9) subscriber's [~~Subscriber's~~] sex [~~gender~~] is required;

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

(11) subscriber's plan or group [~~Subscriber's plan/group~~] number is

required, if shown on the patient's ID card;

(12) and (13) (No change.)

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

(15) other [~~Other~~] insured's or enrollee's name is required as called for by [~~in accordance with~~] the response to and requirements of paragraph (14) [~~(15)~~]of this subsection;

(16) other [~~Other~~] insured's or enrollee's date of birth is required as called for by [~~in accordance with~~] the response to and requirements of the element in paragraph (14) [~~(15)~~] of this subsection;

(17) other [~~Other~~] insured's or enrollee's sex [~~gender~~] is required as called for by [~~in accordance with~~] the response to and requirements of the element in paragraph (14) [~~(15)~~] of this subsection;

(18) other [~~Other~~] insured's or enrollee's identification number is required as called for by [~~in accordance with~~] the response to and requirements of the element in paragraph (14) [~~(15)~~] of this subsection;

(19) patient's [~~Patient's~~]relationship to other insured or enrollee is

required as called for by [~~in accordance with~~] the response to and requirements of the element in paragraph (14) [~~(15)~~] of this subsection;

(20) name [~~Name~~] of other HMO or insurer is required as called for by [~~in accordance with~~] the response to and requirements of the element in paragraph (14) [~~(15)~~] of this subsection;

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

(22) date(s) [~~Date(s)~~] of service(s) or procedure(s) is required;

(23) area [~~Area~~] of oral cavity is required, if applicable;

(24) tooth [~~Tooth~~] system is required, if applicable;

(25) tooth [~~Tooth~~] number(s) or letter(s) are required, if applicable;

(26) tooth [~~Tooth~~] surface is required, if applicable;

(27) procedure [~~Procedure~~] code for each service is required;

(28) description [~~Description~~] of procedure for each service is required, if applicable;

(29) charge [~~Charge~~] for each listed service is required;

(30) total [~~Total~~] charge for the claim is required;

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

(32) notification [~~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) [~~and (35)~~] of this subsection are required;

(33) date [~~Date~~] of orthodontic appliance placement is required, if applicable;

(34) months [~~Months~~] of orthodontic treatment remaining is required, if applicable;

(35) notification [~~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 [~~Date~~] of prior prosthesis placement is required, if applicable;

(37) name [~~Name~~] of billing provider is required;

(38) address [~~Address~~] of billing provider is required;

(39) billing [~~Billing~~] provider's provider identification number is required, if applicable;

(40) billing [~~Billing~~] provider's license number is required;

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

(42) billing [~~Billing~~] provider's telephone number is required; and

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

(d) Coordination of benefits or nonduplication [~~non-duplication~~] of benefits.

(1) If a claim is submitted for covered services or benefits for [~~in~~] which coordination of benefits is necessary under [~~pursuant to~~] §§3.3501 − 3.3511 of this title

(relating to Group Coordination of Benefits), a successor rule adopted by the commissioner, or [and] §11.511(1) of this title (relating to Optional Provisions) [is necessary], the amount paid as a covered claim by the primary plan is a required element of a clean claim for purposes of the secondary plan's [processing of the] claim processing and CMS-1500 (02/12), field 29, or CMS-1500 (08/05), field 29, or [; CMS-1500(12/90), field 29;] UB-04, field 54 [; or UB-92, field 54], as applicable, must be completed under [pursuant to] subsection (b)(1)(GG), (2)(KK), [(b)(1)(KK) and [, (2)(II),] (3)(BB) [, and (4)(GG)] of this section.

(2) If a claim is submitted for covered services or benefits for [in] which nonduplication [non-duplication] of benefits under [pursuant to] §3.3053 of this title (relating to Non-duplication of Benefits Provision) is an issue, the amounts paid as a covered claim by all other valid coverage is a required element of a clean claim, and CMS-1500 (02/12), field 29, or CMS-1500 (08/05), field 29, or [; CMS-1500 (12/90), field 29;] UB-04, field 54 [; or UB-92, field 54], as applicable, must be completed under [pursuant to] subsection (b)(1)(GG), (2)(KK), [(b)(1)(KK)] and [, (2)(II),] (3)(BB) [, and (4)(GG)] of this section.

(3) If a claim is submitted for covered services or benefits and the policy contains a variable deductible provision as set forth in §3.3074(a)(4) of this title (relating to Minimum Standards for Major Medical Expense Coverage), the amount paid as a covered claim by all other health insurance coverages, except for amounts paid by individually underwritten and issued hospital confinement indemnity, specified disease, or limited benefit plans of coverage, is a required element of a clean claim, and CMS-

1500 (02/12), field 29, or CMS-1500 (08/05), field 29, or [~~; CMS-1500 (12/90), field 29;~~] UB-04, field 54 [~~; or UB-92, field 54~~], as applicable, must be completed under [~~pursuant to~~] subsection (b)(1)(GG), (2)(KK), [~~(b)(1)(KK)~~] and [~~, (2)(II),~~] (3)(BB) [~~, and (4)(GG)~~] of this section. Despite [~~Notwithstanding~~] these requirements, an MCC [~~HMO or preferred provider carrier~~] 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 [~~submitting a claim~~] using the applicable format that complies with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides, and trading partner agreements.

(f) Coordination of benefits on electronic clean claims. If a physician or a provider submits an electronic clean claim that requires coordination of benefits under [~~pursuant to~~] §§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 MCC [~~HMO or preferred provider carrier~~] processing the claim as a secondary payor must [~~shall~~] 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 forth in subsections (b) – (f) [~~(b), (c), (d), (e), and (f),~~] of this section, as [~~if~~] 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 [~~shall~~] 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 [~~HMO or preferred provider carrier~~] may, within 30 days of receipt of a clean claim, request additional information from the treating preferred provider. The time [~~period~~] to request additional information may be extended as allowed by §21.2819(c) of this title (relating to Catastrophic Event). An MCC [~~HMO or preferred provider carrier~~] may make only one request to the submitting treating preferred provider for information under this section.

(b) (No change.)

(c) An MCC [~~HMO or preferred provider carrier~~] that requests information under this section must [~~shall~~] determine whether the claim is payable and pay or deny the claim, or audit the claim in compliance [~~accordance~~] 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 [~~HMO or preferred provider carrier~~] receives the requested information as required under subsection (e) of this section;

(2) the 15th day after the date the MCC [~~HMO or preferred provider carrier~~] 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) (No change.)

(e) An MCC [~~HMO or preferred provider carrier~~] must [~~shall~~] 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 [~~HMO or preferred provider carrier~~], the date of service, and the name of the treating preferred provider. If the MCC [~~HMO or preferred provider carrier~~] submitted the request for additional information electronically in compliance [~~accordance~~] with federal requirements concerning electronic transactions, the treating preferred provider must submit the response in compliance [~~accordance~~] 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) (No change.)

§21.2805. Requests for Additional Information from Other Sources.

(a) If an MCC [~~HMO or preferred provider carrier~~] requests additional information from a person other than the preferred provider who submitted the claim, the MCC [~~HMO or preferred provider carrier~~] must [~~shall~~] provide [~~,~~] to the preferred provider who submitted the claim [~~,~~] a notice containing the name of the physician, the provider, or the other entity from whom the MCC [~~HMO or preferred provider carrier~~] is requesting

information. The MCC [~~HMO or preferred provider carrier~~] may not withhold payment beyond the applicable [~~21-, 30- or 45-day~~] 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 [~~HMO or preferred provider carrier~~] determines that there was an error in payment of the claim, the MCC [~~HMO or preferred provider carrier~~] may recover any overpayment under §21.2818 of this title (relating to Overpayment of Claims).

(b) An MCC [~~HMO or preferred provider carrier~~] must [~~shall~~] request that the entity responding to a request made under this section [~~to~~] attach a copy of the request to the response. If the request for additional information was submitted electronically in compliance with [~~in accordance with~~] applicable federal requirements concerning electronic transactions, the responding entity must submit the response in compliance with [~~shall be submitted in accordance with~~] those requirements, if applicable.

(c) (No change.)

§21.2806. Claim [~~Claims~~] Filing Deadline.

(a) Claim submission deadline. A physician or a provider must submit a claim to an MCC [~~HMO or preferred provider carrier~~] not later than the 95th day after the date the physician or the provider delivers [~~provides~~] the medical care or health care services for which the claim is made. An MCC [~~HMO or preferred provider carrier~~] 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 [~~accordance~~] with §21.2819 of this title (relating to Catastrophic Event).

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

(d) Determining date of submission. Section 21.2816 [~~§21.2816~~] of this title (relating to Date of Receipt) determines the date an MCC [~~HMO or preferred provider carrier~~] receives a claim.

(e) Duplicate claims.

(1) A physician or a provider may not submit a duplicate claim prior to the 46th day, or the 31st day if filed electronically, [~~or the 22nd day if a claim for prescription benefits,~~] 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 prior to 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 [~~HMO or preferred provider carrier~~] that receives a duplicate claim prior to the applicable date specified in paragraphs (1) and (2) of this subsection [~~46th day after receipt of the original claim, a duplicate electronic claim prior to the 31st day after receipt of the original claim, or a duplicate claim for prescription benefits prior to the 22nd day after receipt of the original claim~~] is not subject to the provisions of §21.2807 [~~§§21.2807~~] of this title (relating to Effect of Filing a Clean Claim) or §21.2815 [~~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 upon receipt of a clean claim, including a corrected claim that is a clean claim, from a preferred provider, under [~~pursuant to~~] §21.2816 of this title (relating to Date of Receipt), at the address designated by the MCC [~~HMO or preferred provider carrier~~], in compliance [~~accordance~~] with §21.2811 of this title (relating to Disclosure of Processing

Procedures), whether it be the address of the MCC [~~HMO, preferred provider carrier,~~] or any other entity, including a clearinghouse or a repricing company, designated by the MCC [~~HMO or preferred provider carrier~~] 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 [~~,~~] prior to the expiration of the applicable statutory claims payment period specified in §21.2802 of this title (relating to Definitions), an MCC must [~~HMO or preferred provider carrier shall~~]:

(1) pay the total amount of the clean claim as specified in [~~in accordance with~~] the contract between the preferred provider and the MCC [~~HMO or preferred provider carrier~~];

(2) deny the clean claim in its entirety after a determination that the MCC [~~HMO or preferred provider carrier~~] 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 [~~100%~~] of the contracted rate on the claim to the preferred provider; or

(4) pay the portion of the clean claim for which the MCC [~~HMO or preferred provider carrier~~] acknowledges liability as specified in [~~in accordance with~~] the contract between the preferred provider and the MCC [~~HMO or preferred provider carrier~~], and:

(A) deny the remainder of the clean claim after a determination that the MCC [~~HMO or preferred provider carrier~~] 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 [~~100%~~] of the contracted rate on the unpaid portion of the clean claim to the preferred provider.

(c) [~~With regard to a clean claim for a prescription benefit subject to the statutory claims payment period specified in §21.2802 of this title, an HMO or preferred provider carrier shall, after receipt of an electronically submitted clean claim for a prescription benefit that is affirmatively adjudicated pursuant to Insurance Code Article 3.70-3C, §3A(f) (Preferred Provider Benefit Plans) and Insurance Code §843.339, pay the prescription benefit claim within 21 calendar days after the clean claim is adjudicated.~~]

[~~(d)~~] An MCC or an MCC's [~~HMO or preferred provider carrier or an HMO's or preferred provider carrier'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 [~~HMO or preferred provider carrier~~] determines that a submitted claim is [~~to be~~] deficient, the MCC must [~~HMO or preferred provider carrier shall~~] notify the preferred provider submitting the claim that the claim is deficient within 45 calendar days of the MCC's [~~HMO's or preferred provider carrier's~~] receipt of the nonelectronic claim, or within 30 days of receipt of an electronic claim. If an MCC [~~HMO or preferred provider carrier~~] determines that a [~~an electronically submitted~~] claim for a prescription benefit is [~~to be~~] deficient, the MCC

must [~~HMO or preferred provider carrier shall~~] notify the provider that the claim is deficient within 21 calendar days of the MCC's [~~HMO's or preferred provider carrier'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 [~~HMO or preferred provider carrier~~] 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 [~~§21.2802(28)~~] of this title (relating to Definitions) and intends to audit the claim to determine whether the claim is payable, the MCC must [~~HMO or preferred provider carrier shall~~] notify the preferred provider that the claim is being audited and pay 100 percent [~~100%~~] of the contracted rate within the applicable statutory claims payment period.

(b) Failure to provide notice and payment. An MCC [~~HMO or preferred provider carrier~~] that fails to provide notice [~~notification~~] of the decision to audit the claim and pay 100 percent [~~100%~~] 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 forth in this section. A preferred provider that receives less than 100 percent [~~100%~~] of the contracted rate [~~in conjunction~~] with a notice of intent to audit has received an underpayment and must notify the MCC [~~HMO or preferred provider carrier~~] within 270 [~~180~~] days in compliance [~~accordance~~] with the provisions of §21.2815(f)(2)

[§21.2815(e)(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) [(b)] Explanation of payment. The MCC [HMO or preferred provider carrier] must [shall] clearly indicate on the explanation of payment that the claim is being audited and that the preferred provider is being paid 100 percent [100%] of the contracted rate, subject to completion of the audit. A nonelectronic [paper] explanation of payment complies with this requirement if the notice of the audit is clearly and prominently identified.

(d) [(c)] Audit deadline and requirements. The MCC must [HMO or preferred provider carrier shall] complete the audit within 180 calendar days from receipt of the clean claim. The HMO or preferred provider carrier must [shall] provide written notice [notification] of the results of the audit. The MCC must include in the notice [shall include] a listing of the specific claims paid and not paid under [pursuant to] 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 [HMO or preferred provider carrier] seeking recovery of any refund under this section must [shall] comply with the procedures set forth in §21.2818 of this title (relating to Overpayment of Claims).

(e) [(d)] Requests for information. An MCC [HMO or preferred provider carrier] 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 [pursuant to] the requirements of Insurance Code §1301.105 [Article 3.70-3C §3A(g)] 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) [~~(e)~~] Opportunity for appeal. Prior to seeking a refund for a payment made under this section, an MCC [~~HMO or preferred provider carrier~~] must provide a preferred provider with the opportunity to appeal the request for a refund in compliance [~~accordance~~] with §21.2818 of this title. An MCC [~~HMO or preferred provider carrier~~] 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) [~~(f)~~] No admission of liability. Payments made under [~~pursuant to~~] this section on a clean claim are not an admission that the MCC [~~HMO or preferred provider carrier~~] 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 upon by the contracting parties, an MCC [~~HMO or preferred provider carrier~~] must disclose to its preferred providers:

(1) (No change.)

(2) the telephone number to [~~at~~] 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 [~~HMO or preferred provider carrier~~] has delegated claim payment functions [~~, if applicable~~]; and

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

(b) An MCC must [~~HMO or preferred provider carrier shall~~] 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 [~~with whom the HMO or preferred provider carrier has contracts~~].

§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 [~~HMO or preferred provider carrier~~] may not premise the denial of a clean claim upon a preferred provider's failure to file a [~~clean~~] claim within the claim [~~claims~~] filing deadline set forth in §21.2806 of this title (relating to Claim [~~Claims~~] 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) [~~has been given~~].

§21.2813. Requirements Applicable to Other Contracting Entities. Any contract or delegation agreement between an MCC [~~HMO or preferred provider carrier~~] 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 [~~be construed to~~] limit the MCC's [~~HMO's or preferred provider carrier's~~] authority or responsibility to comply with all applicable statutory and regulatory requirements.

§21.2814. [~~Electronic~~] Adjudication of Prescription Benefits. If a prescription benefit does not require authorization by an MCC [~~HMO or preferred provider carrier~~],

the statutory claims payment period must [~~shall~~] begin on the date of affirmative adjudication of the [~~a~~] claim for a prescription benefit [~~that is electronically transmitted~~].

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

(a) An MCC [~~HMO or preferred provider carrier~~] that determines under §21.2807 of this title (relating to Effect of Filing a Clean Claim) that a claim is payable must [~~shall~~] 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 [~~21-, 30- or 45-day~~] statutory claims payment period, pay to a noninstitutional [~~the~~] preferred provider [~~, in addition to the contracted rate owed on the claim,~~] a penalty in the amount of the lesser of:

(A) (No change.)

(B) $100,000; [~~.~~]

(2) if [~~If~~] the claim is paid on or after the 46th day and before the 91st day after the end of the applicable [~~21-, 30- or 45-day~~] statutory claims payment period, pay to a noninstitutional [~~the~~] preferred provider, [~~, in addition to the contracted rate owed on the claim,~~] a penalty in the amount of the lesser of:

(A) (No change.)

(B) $200,000; [~~.~~]

(3) if [~~If~~] the claim is paid on or after the 91st day after the end of the applicable [~~21-, 30- or 45-day~~] statutory claims payment period: [~~,~~]

(A) pay to the noninstitutional preferred provider [~~, in addition to the contracted rate owed on the claim,~~] 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 (the department) [~~plus~~] 18 percent annual interest on the penalty amount paid to a noninstitutional preferred provider under paragraph (2) of this subsection. Interest under this paragraph [~~subsection~~] accrues beginning on the date the MCC [~~HMO or preferred provider carrier~~] 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 subparagraphs (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 subparagraphs (A) or (B) of this paragraph. The MCC must pay 50 percent of the penalty to the institutional

preferred provider and fifty 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) [~~(a)~~] of this section:

(1) if [~~If~~] the contracted rate, including any patient financial responsibility, is $10,000 and the billed charges are $15,000, and the MCC [~~HMO or preferred~~

~~provider carrier~~] pays the claim on or before the 45th day after the end of the applicable statutory claims payment period, the MCC [~~HMO or preferred provider carrier~~] must [~~shall~~] 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 [~~HMO or preferred provider carrier~~] must [~~shall~~] 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 [~~HMO or preferred provider carrier~~] must [~~shall~~] 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 [~~, plus~~] 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 [~~HMO or preferred provider carrier~~] 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 [~~21-, 30- or 45-~~

~~day~~] 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: [~~shall:~~]

(1) if [~~If~~] the balance of the claim is paid to a noninstitutional preferred provider on or before the 45th day after the applicable [~~21-, 30- or 45-day~~] statutory claims payment period, pay to the preferred provider [~~, in addition to the contracted amount owed,~~] a penalty on the amount not timely paid in the amount of the lesser of:

(A) (No change.)

(B) $100,000; [~~.~~]

(2) if [~~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 [~~21-, 30- or 45-day~~] statutory claims payment period, pay to the preferred provider [~~, in addition to the contracted amount owed,~~] a penalty in the amount of the lesser of:

(A) (No change.)

(B) $200,000; [~~.~~]

(3) if [~~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 [~~21-, 30- or 45-day~~] statutory claims payment period, pay to the preferred provider [~~, in addition to the contracted amount owed,~~] 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 [~~HMO or preferred provider carrier~~] 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 [~~carrier~~] 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 [~~HMO or preferred provider carrier~~] owing a balance of $200. The MCC [~~HMO or preferred provider carrier~~] pays the $200 balance on the 30th day after the end of the applicable statutory claims payment period. The amount the MCC [~~HMO or preferred provider carrier~~] initially underpaid, $200, is 20 percent of the contracted rate. To determine the penalty, the MCC [~~HMO or preferred provider carrier~~] 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 [~~Therefore, the~~] MCC [~~HMO or preferred provider carrier~~] must pay, as a penalty, 50 percent of $100, or $50.

(e) For purposes of calculating a penalty when an MCC [~~HMO or preferred provider carrier~~] is a secondary plan MCC [~~carrier~~] for a claim, the contracted rate and

billed charges must be reduced in proportion to [~~accordance with~~] the percentage of the entire claim that is owed by the secondary plan MCC [~~carrier~~]. 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 [~~pursuant to~~] 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 [~~therefore~~] 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 [~~than~~] 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 [~~HMO or preferred provider carrier~~] is not liable for a penalty under this section:

(1) if the failure to pay the claim within [~~in accordance with~~] the applicable statutory claims payment period is a result of a catastrophic event that the MCC [~~HMO or preferred provider carrier~~] certified according to the provisions of §21.2819 of this title (relating to Catastrophic Event); or

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

(A) the preferred provider notifies the MCC [~~HMO or preferred provider carrier~~] of the underpayment after the 270th day after the date the underpayment was received; and

(B) the MCC [~~HMO or preferred provider carrier~~] 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 [~~HMO or preferred provider carrier~~] of the obligation to pay the remaining unpaid contracted rate owed the preferred provider.

(h) An MCC [~~HMO or preferred provider carrier~~] that pays a penalty under this section must [~~shall~~] 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 [~~non-electronic~~] 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 [~~shall~~] 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) − (4) (No change.)

(c) and (d) (No change.)

(e) If a claim is submitted electronically, the claim is presumed received on the date of the electronic verification of receipt by the MCC [~~HMO or preferred provider carrier~~] or the MCC's [~~HMO's or preferred provider carrier's~~] clearinghouse. If the MCC's [~~HMO's or preferred provider carrier'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 [~~shall~~] 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) and (g) (No change.)

(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 [~~shall~~] 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 [~~shall~~] identify each separate claim, request for information, or response included in a batch communication. The mail log must [~~shall~~] 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 [~~HMO or preferred provider~~

~~carrier~~]; designated address; [~~,~~] date of mailing or hand delivery; subscriber name; subscriber ID number; patient name; date(s) of service or occurrence; [~~service/occurrence,~~] delivery method; [~~,~~] and claim number, if applicable.

§21.2817. Terms of Contracts. Unless otherwise provided in this subchapter, contracts between MCCs [~~HMOs or preferred provider carriers~~] and preferred providers may [~~shall~~] not include terms that [~~which~~]:

(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 [~~pursuant to~~] Insurance Code §1301.108 [~~Article 3.70-3C §3A(n)~~] and §843.343.

§21.2818. Overpayment of Claims.

(a) An MCC [~~HMO or preferred provider carrier~~] may recover a refund due to overpayment or completion of an audit if:

(1) the MCC [~~HMO or preferred provider carrier~~] 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 [~~HMO or preferred provider carrier~~] notifies the physician or the provider of the completion of an audit under §21.2809 of this title [~~the subchapter~~] (relating to Audit Procedures [~~Audits~~]).

(b) Notification under subsection (a) of this section must [~~shall~~]:

(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) (No change.)

(3) describe the methods by which the MCC [~~HMO or preferred provider carrier~~] 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. Upon receipt of written notice under this subsection, the MCC must [~~HMO or preferred provider carrier shall~~] begin the appeal process provided for in the MCC's [~~HMO's or preferred provider carrier's~~] contract with the physician or the provider.

(d) An MCC [~~HMO or preferred provider carrier~~] 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 [~~HMO or preferred provider carrier~~]; 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 [~~HMO or preferred provider carrier~~].

(e) If an MCC [~~HMO or preferred provider carrier~~] is a secondary payor and pays

a portion of a claim that should have been paid by the MCC [~~HMO or preferred provider carrier~~] that is the primary payor, the secondary payor may only recover overpayment from the MCC [~~HMO or preferred provider carrier~~] 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 forth in this section.

(f) Subsections (a) – [~~through~~] (e) of this section do not affect an MCC's [~~a carrier'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, [~~HMO, preferred provider carrier,~~] 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 [~~Request~~] for Additional Information from Treating Preferred Provider), 21.2806 (relating to Claim [~~Claims~~] Filing Deadline), 21.2807 (relating to Effect of Filing a Clean Claim), 21.2808 (relating to Effect of Filing a Deficient Claim), 21.2809 (relating to Audit Procedures), and 21.2815 [~~of this title~~] (relating to Failure to Meet the Statutory Claims Payment Period), of this title, 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 [~~ten~~] 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 [~~department, to the Life/Health/HMO Filings Intake Division~~], 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 [~~administrators~~], or their designees; or

(B) for an MCC, [~~HMO or preferred provider carrier,~~] a corporate officer or a [~~the~~] 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 [~~HMO or preferred provider carrier~~].

(c) (No change.)

§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, [~~or~~] a preferred provider benefit plan, or an exclusive provider benefit plan that is issued by an MCC [~~HMO or preferred provider carrier~~] subject to this subchapter [~~pursuant to §21.2801 of this title (relating to Scope)~~] must [~~shall~~] comply with the requirements of this section.

(b) An identification card or other similar document issued to enrollees or to insureds must [~~shall~~] 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; [~~and~~]

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

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

[~~(c) The requirements of this section apply to an HMO evidence of coverage or a preferred provider benefit plan issued or renewed on or after February 1, 2004.~~]

§21.2821. Reporting Requirements.

(a) An MCC must [~~HMO or preferred provider carrier shall~~] submit to the department quarterly claims payment information in compliance [~~accordance~~] with the requirements of this section.

(b) The MCC must [~~HMO or preferred provider carrier shall~~] 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 HMO or preferred provider carrier shall submit the first report required by this section to the department on or before February 15, 2004 and shall include information for the months of September, October, November and December of the prior calendar year.~~] [~~(d)~~] The report required by subsection (a) of this section must [~~shall~~] include, at a minimum, the following information:

(1) number of claims received from noninstitutional [~~non-institutional~~] preferred providers;

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

(3) number of clean claims received from noninstitutional [~~non-institutional~~] preferred providers;

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

(5) number of clean claims from noninstitutional [~~non-institutional~~] preferred providers paid within the applicable statutory claims payment period;

(6) number of clean claims from noninstitutional [~~non-institutional~~] 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 [~~non-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;

(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 [~~non-institutional~~] 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 [~~pursuant to~~] the provisions of §21.2809 of this title (relating to Audit Procedures);

(14) number of requests for verification received under [~~pursuant to~~] §19.1719 [~~§19.1724~~] of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans);

(15) number of verifications issued under [~~pursuant to~~] §19.1719 [~~§19.1724~~] of this title;

(16) number of declinations of requests for verifications, under [~~pursuant to~~] §19.1719 [~~§19.1724~~] 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 [~~HMO or preferred provider carrier~~];

(20) number of electronically submitted, affirmatively adjudicated pharmacy claims paid within the 18-day [~~21-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 [~~21-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 [~~21-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 [~~21-day~~] statutory claims payment period.

(d) [~~(e)~~] An MCC must [~~HMO or preferred provider carrier shall~~] 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 [~~timeframes~~] 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; [cancelled;]

(E) preexisting [pre-existing] condition limitations; and

(F) other; [.]

(2) declinations due to an inability to obtain necessary information in order 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 [HMO or preferred provider carrier] that fails to comply with §21.2807 of this title (relating to Effect of Filing a Clean Claim) for more than two percent of clean claims submitted to the MCC [HMO or preferred provider carrier] is subject to an administrative penalty under [pursuant to the] Insurance Code[,] §843.342(k) or §1301.137(k) [Article 3.70-3C section 3I(k)], as applicable.

(b) The percentage of the MCC's [HMO or preferred provider carrier's] compliance with §21.2807 of this title must [shall] be determined on a quarterly basis and must [shall] 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 [~~Non-Contracting~~] Physicians and Providers. The provisions of §19.1719 [~~§§19.1724~~] of this title (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans) and §21.2807 of this title (relating to [~~Verification and~~] Effect of Filing a Clean Claim) apply to a physician or a provider that provides to an enrollee or an insured of an MCC [~~HMO or preferred provider carrier~~]:

(1) (No change.)

(2) specialty or other medical care or health care services at the request of the MCC, [~~HMO, preferred provider carrier~~], 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 [~~HMO's or preferred provider carrier'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 [~~pursuant to~~] contracts entered into or renewed between an MCC [~~HMO or preferred provider carrier~~] and a preferred provider on or after October 5, 2003, and to services provided or hospital confinements beginning on or after October 5, 2003, by physicians and providers that do not have a contract with an MCC [~~HMO or preferred provider carrier~~].

§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 inconsistent with any statutes of this state, is unconstitutional, or~~] 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 [~~remaining provisions of this subchapter shall remain in full effect~~].

§21.2826. Waiver. In compliance with Insurance Code §1211.001, the [~~The~~] provisions in [~~of~~] [~~Texas~~] Insurance Code Chapter 1301, §1301.069, §1301.162, and Subchapters C and C-1; Chapter 1213; [~~Articles 3.70-3C, Sections 3A, 3C-3J, 10-12; and 21.52Z;~~] Chapter 843, §843.209, §843.319, and Subchapter J [~~and Sections 843.209 and 843.319~~]; as well as this subchapter and §§3.3703(a)(20), 11.901(a)(11) [~~§§3.3703(20), 11.901(10)~~], 19.1718 [~~19.1723~~], and 19.1719 [~~19.1724~~] 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 [~~(CHIP)~~] plans provided by an MCC [~~HMO or preferred provider carrier~~] to persons enrolled in the medical assistance program established under [~~Chapter 32,~~] Human Resources Code Chapter 32 [~~,~~] or the child health plan established under [~~Chapter 62,~~] Health and Safety Code Chapter 62.

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

Issued in Austin, Texas, on October 31, 2013.

Sara Waitt, General Counsel
Texas Department of Insurance