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

1. INTRODUCTION. The Texas Department of Insurance proposes amendments to §21.2802 and §21.2803 concerning elements of a clean health care claim. In conjunction with the National Uniform Claims Committee (NUCC) and the National Uniform Billing Committee (NUBC), 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 claims. Insurance Code §1204.102 requires a provider to use one of two forms, HCFA 1500 and UB-82/HCFA, or their successor forms, for submission of certain claims. These amendments are necessary to implement usage of two new successor forms, the CMS-1500 (08/05) and the UB-04 CMS-1450. These amendments are also necessary to address the phase-out of the two predecessor successor forms, the CMS-1500 (12/90) and the UB-92 CMS-1450, currently required for use in filing certain claims. The amendments further address changes to specified data elements necessary to accommodate revision of the information fields set forth in the two new successor forms, update internal references and references related to nonsubstantive recodification, and make minor punctuation and grammatical changes.

§21.2802. Definitions. The proposed amendment to §21.2802 adds a definition for the NPI (National Provider Identifier) number, a standard unique health

identifier number for health care providers assigned pursuant to federal law for which the new successor forms have created specific information fields, and renumbers subsequent definitions accordingly.

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

§21.2803(b). Required data elements. The proposed amendments to §21.2803(b) adopt successor forms for specified claims; establish optional timelines to allow for transition to the new forms; establish required usage dates; and establish the data elements required for a physician or provider to submit a clean claim.

§21.2803(b)(1). Successor form CMS-1500 (08/05). The proposed amendments redesignate current subsection (b)(1) as subsection (b)(2) and add a new subsection (b)(1) to §21.2803. Specifically, proposed new §21.2803(b)(1) adopts successor form CMS-1500 (08/05) as the required form for physicians and noninstitutional providers for claims filed or re-filed on or after April 2, 2007, and sets forth the data elements that physicians and noninstitutional providers must

complete in accordance with this paragraph for clean claims. The proposal further creates an optional transition period prior to the mandatory usage date of April 2, 2007. Upon notification by an HMO or a preferred provider carrier that it is prepared to accept claims filed or re-filed prior to April 2, 2007, using form CMS-1500 (08/05), a physician or non-institutional provider may submit claims using that successor form, subject to the data element requirements set forth in the paragraph for clean claims for form CMS-1500 (08/05). Most of the proposed data element requirements in new §21.2803(b)(1) are consistent with those data element requirements identified for use in clean claims on the predecessor form CMS-1500 (12/90). The proposal identifies the field location of those data elements on successor form CMS-1500 (08/05).

Proposed new §21.2803(b)(1)(H) – (L) and (Q) do not contain the phrase "to the HMO or preferred provider carrier." Although the current rule regarding these data elements contains this phrase, the language is unnecessary because these subparagraphs already specify that, when required according to the instructions in these subparagraphs, the physician or provider must submit *with the claim* documented proof that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete the data element. This proposed change is consistent with proposed amendments to address the corresponding data elements in §21.2803(b)(2)(H) – (L) and (Q), regarding required data elements

for the CMS-1500 (12/90) during the phase-out of that form, and does not substantively change requirements regarding these data elements.

Proposed new §21.2803(b)(1)(U) clarifies the circumstances in which a physician or provider must enter the name of a referring primary care physician, specialty physician, hospital, or other source of referral, and does not effect a substantive change. Proposed new §21.2803(b)(1)(V) similarly clarifies the circumstances in which a physician or provider must submit the ID Number of the referring primary care physician, specialty physician, or hospital. Because the physician or provider should already have submitted an entry affirming the nonexistence of a referring provider in field 17 when appropriate, the proposal does not require duplication of this information in field 17a.

Proposed new §21.2803(b)(1)(W) requires that, for claims filed or re-filed on or after May 23, 2007, if there is a referring physician noted in field 17, the physician or provider filing the claim must enter the NPI number of the referring primary care physician, specialty physician, or hospital, if the referring physician is eligible for an NPI number. Proposed new §21.2803(b)(1)(GG), (NN), and (PP) address similar NPI number submission requirements for rendering providers, facilities, and billing providers. This NPI number usage requirement is consistent with CMS requirements and timelines for standard transactions and will support federal implementation of the NPI number. Further, this usage requirement allows for greater consistency between standard and nonstandard transactions and strengthens the ability of physicians and providers to submit

clean electronic claims by promoting the use of the NPI number in nonstandard transactions.

Proposed new §21.2803(b)(1) further recognizes that the *CMS Final Rule for HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers, Subpart D*, does not require a small health plan to comply with implementation specifications for use of the NPI number until May 23, 2008. Proposed new §21.2803(b)(1)(V) therefore requires submission of the ID number of the referring primary care physician, specialty physician, or hospital as applicable. This proposal is a continuation of the requirement applicable to the predecessor form CMS-1500 (12/90) and enables small health plans to identify physicians prior to May 23, 2008. Similarly, and for the same reason, proposed new §21.2803(b)(1)(QQ) continues the required submission of the rendering provider number if the HMO or preferred provider carrier required provider numbers and notified physicians and providers of the requirement prior to June 17, 2003. Proposed new §21.2803(b)(1)(OO) and (QQ) further reflect that information currently captured together in field 33 on form CMS-1500 (12/90) now has discrete subfields in form CMS-1500 (08/05).

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

§21.2803(b)(2). Predecessor form CMS-1500 (12/90). The proposed amendments to redesignated §21.2803(b)(2) (subsection (b)(1) in the current rule) address the phase-out period of form CMS-1500 (12/90) and renumber this paragraph in accord with the new structure of the section. The proposed amendments specify that physicians and noninstitutional providers filing or re-filing nonelectronic claims prior to April 2, 2007, must use predecessor form CMS-1500 (12/90), continuing the data element requirements applicable to that form for clean claims. The proposed amendments further provide that upon notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on form CMS-1500 (08/05), a physician or noninstitutional provider may submit claims using form CMS-1500 (08/05) prior to the April 2, 2007, mandatory usage date, subject to the required data elements set forth in proposed new §21.2803(b)(1).

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

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

§21.2803(b)(3). Successor form UB-04 CMS-1450. The proposed amendments redesignate current subsection (b)(2) as subsection (b)(4) and add a new subsection (b)(3). Proposed new §21.2803(b)(3) adopts successor form UB-04 CMS-1450 as the required form for institutional providers for nonelectronic claims filed or re-filed on or after May 23, 2007, and sets forth the data elements that institutional providers must complete in accordance with this paragraph for clean claims. The proposal further creates an optional transition period prior to the mandatory usage date of May 23, 2007. Between March 1, 2007 and May 22, 2007, upon notification from an HMO or preferred provider carrier that it is prepared to accept claims filed or re-filed on the new successor form, an institutional provider may submit claims using successor form UB-04 CMS-1450, subject to the data elements set forth in §21.2803(b)(3) for clean claims. Most of the data element requirements in new §21.2803(b)(3) are consistent with those data element requirements previously identified for use in clean claims on the predecessor form UB-92 CMS-1450.

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

Proposed new §21.2803(b)(3) does not set forth discrete data element requirements for covered days; non-covered days; coinsurance days; or lifetime reserve days, as are required for the UB-92. The UB-04 form no longer contains assigned fields for these specific purposes. Instead, a clean noninstitutional provider claim must include value codes corresponding to this information as appropriate and as set forth in §21.2803(b)(3)(S).

Proposed new §21.2803(b)(3) reflects the NUBC's reorganization/renumbering of field assignments on the UB-04. The proposal does not include marital status, submission of the procedure coding method used, or signature of the provider representative as required data elements for the UB-04. While the Department requires submission of this information for clean claims on the current form, the UB-04 no longer contains assigned fields for these purposes. Because the UB-04 no longer contains a field assignment for prior patient payments, proposed new §21.2803(b)(3) does not include this data element requirement.

Proposed new §21.2803(b)(3)(CC) requires an institutional provider to submit the billing provider's NPI number for claims filed or re-filed on or after May 23, 2007 if the billing provider is eligible for an NPI number. Proposed new §21.2803(b)(3)(OO) contains a similar NPI number submission requirement for the attending physician. As stated with regard to the proposed required clean claim elements for the CMS-1500 (08/05), this NPI number usage requirement is consistent with CMS requirements and timelines for standard transactions and

will support federal implementation of the NPI number. The usage requirement further allows for greater consistency between standard and nonstandard transactions and strengthens the ability of institutional providers to submit clean electronic claims by promoting the use of the NPI number in nonstandard transactions.

Also consistent with the proposed rule regarding the required clean claim elements for the CMS-1500 (08/05), proposed new §21.2803(b)(3) recognizes that the *CMS Final Rule for HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers, Subpart D*, does not require a small health plan to comply with its implementation specifications for use of the NPI number until May 23, 2008. Accordingly, proposed new §21.2803(b)(3)(DD) requires an institutional provider to submit the payor-designated provider number if the HMO or preferred provider carrier required provider numbers and gave notice of that requirement to physicians and providers prior to June 17, 2003. Similarly, proposed new §21.2803(b)(3)(PP) requires institutional providers to submit the payor-designated attending physician ID. These requirements are a continuation of the requirements applicable to the predecessor form UB-92 and enable small health plans to identify these providers.

§21.2803(b)(4). Predecessor claim form UB-92. The proposed amendments to redesignated §21.2803(b)(4) (subsection (b)(2) in the current rule) address the phase-out period of form UB-92 CMS-1450. The proposed amendments specify

that institutional providers filing or re-filing nonelectronic claims prior to May 23, 2007, must use predecessor form UB-92, continuing the data element requirements applicable to that form for clean claims. The proposed amendments further provide that upon notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on form UB-04 earlier than the mandatory usage date, the institutional provider may submit claims using the UB-04, subject to the data element requirements established in §21.2803(b)(3), at any time between March 1, 2007 and May 22, 2007. The proposed amendment to §21.2803(b)(4)(LL) further deletes a repetitive reference.

§21.2803(d). Coordination of benefits. The proposed amendments to §21.2803(d) update internal references and identify required elements necessary for purposes of a secondary plan's claim processing according to the applicable form.

2. FISCAL NOTE. Jennifer Ahrens, Associate Commissioner for the Life, Health, and Licensing Division, 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 government as a result of the enforcement or administration of the rule. There may be possible start-up costs associated with the re-programming of billing systems to local governmental units that file health care claims that may

be subject to statutory requirements in Insurance Code §§843.336, 1204.102, and 1301.131 requiring that physicians and providers use specified uniform billing forms and successor forms. Such costs are the result of these statutory requirements and not the result of the adoption, administration, or enforcement of the proposed amendments. Because the NUCC, NUBC, and CMS are implementing new forms and discontinuing the forms adopted in current §21.2803, §§843.336, 1204.102, and 1301.131 of the Insurance Code require the amendments included in this proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Ms. Ahrens also has determined that for each year of the first five years the proposed amendments are in effect, the public benefits anticipated as a result of the proposed amendments will be enhanced industry, physician, and provider compliance with federal HIPAA requirements, increased consistency between standard and nonstandard health care transactions, and continued streamlining and standardization of the nonelectronic claims filing and payment process. The resulting increase in efficiency will benefit HMOs, preferred provider carriers, physicians, providers, insureds, and enrollees. Proposed amendments to data elements for predecessor forms are nonsubstantive and therefore will not result in any new economic cost to physicians, providers, HMOs, or preferred provider carriers. The probable economic cost to persons required to comply with the proposed

amendments establishing data element requirements for new successor forms is the result of the statutory requirements in Insurance Code §§843.336, 1204.102, and 1301.131 that physicians and providers use specified uniform claim billing forms and successor forms and not the result of the adoption, administration, or enforcement of the proposed amendments. The implementation of new forms and discontinuation of previous forms by the NUCC, NUBC, and CMS require the amendments included in this proposal. Insurance Code §843.336(d) and §1301.131(c) further 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, providing for the standardization of claims payment processes.

Although such costs stem from legislative requirements the proposal implements rather than the proposal itself, staff provides the following information relevant to implementation costs for affected parties. Estimated personnel costs for re-programming 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 2005,* which indicates that the mean hourly wage for a computer programmer employed by an insurance carrier is $32.14, and the mean hourly wage for a computer programmer in general is $32.40. The amount of time necessary to re-program a provider's billing system or an HMO's or preferred provider carrier's claim processing system will vary

based upon 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 upon the needs of the subject, but the Department notes that the NUCC, NUBC, and CMS have undertaken educational efforts associated with implementation of the successor forms and NPI reporting requirements over the last year, putting physicians, providers, preferred provider benefit plans, and HMOs on notice of pending changes. The Department anticipates that these educational efforts have resulted in early implementation planning by some health plans and providers, thereby reducing the additional time required to implement necessary changes, reducing costs associated with implementation, and generally minimizing the burden to the affected parties. Furthermore, in an effort to craft the proposal to minimize burden and cost to the affected parties, the Department on numerous occasions solicited input on significant aspects of these proposed amendments from members of the Technical Advisory Committee on Claims Processing, as well as solicited informal public comment regarding the proposed changes. Provider organizations report continued educational efforts directed to physicians and providers, and HMOs and preferred provider carrier entities and representative organizations have generally indicated that carriers will be prepared to implement the changes in compliance with the proposed timelines. The effect on small and micro-

businesses should be the same as that for the larger entities. As already indicated, the costs associated with compliance with the proposed amendments will vary based upon 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 pursuant to Texas Gov't 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.

4. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on February 20, 2007, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Katrina Daniel, Special Advisor for Policy Development, Life, Health and Licensing

Program, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The Commissioner will consider the adoption of the proposed amendments in a public hearing under Docket Number 2664 at 10:00 a.m. on February 22, 2007, in Room 100 at the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas 78701. Written and oral comments presented at the hearing will be considered.

5. STATUTORY AUTHORITY. The amendments are proposed under the 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.

6. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

Rule	Statute
§21.2802 and §21.2803	Insurance Code Chapters 843 and 1301 and §1204.102

7. TEXT.

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

(1) - (2) (No change.)

(3) Billed charges--The charges for medical care or health care services included on a claim submitted by a physician or provider. For purposes of this subchapter, billed charges must comply with all other applicable requirements of law, including Texas Health and Safety Code §311.0025, Texas Occupations Code §105.002, and Texas Insurance Code Chapter 552 [~~Art. 21.79F~~].

(4) - (15) (No change.)

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

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

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

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

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

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

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

(23)[~~(22)~~] Preferred provider--

(A) with regard to a preferred provider carrier, a preferred provider as defined by Insurance Code §1301.001 (Definitions) [~~Article 3.70-3C, §1(10) (Preferred Provider Benefit Plans) or Article 3.70-3C, §1(1) (Use of~~

~~Advanced Practice Nurses and Physician Assistants by Preferred Provider Plans)~~].

(B) with regard to an HMO,

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

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

(24)[~~(23)~~] Preferred provider carrier--An insurer that issues a preferred provider benefit plan as provided by Insurance Code Chapter 1301 [~~Article 3.70-3C, Section 2 (Preferred Provider Benefit Plans)~~].

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

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

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

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

(29)[~~(28)~~] Secondary plan--As defined in §3.3506 of this title.

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

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

(A) the 45-calendar-day period in which an HMO or preferred provider carrier shall make claim payment or denial, in whole or in part, after receipt of a non-electronic clean claim pursuant to Insurance Code Chapters 843 and 1301 [~~Article 3.70-3C, §3A (Preferred Provider Benefit Plans) and Chapter 843~~];

(B) the 30-calendar-day period in which an HMO or preferred provider carrier shall make claim payment or denial, in whole or in part, after receipt of an electronically submitted clean claim pursuant to Insurance Code Chapters 843 and 1301 [~~Article 3.70-3C, §3A (Preferred Provider Benefit Plans) and Chapter 843~~]; or

(C) the 21-calendar-day period in which an HMO or preferred provider carrier shall make claim payment after affirmative adjudication of an electronically submitted clean claim for a prescription benefit pursuant to Insurance Code Chapters 843 and 1301 [~~Article 3.70-3C, §3A(f) (Preferred Provider Benefit Plans) and §843.339~~], and §21.2814 of this title (relating to Electronic Adjudication of Prescription Benefits).

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

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

§21.2803. Elements of a Clean Claim.

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

(1) (No change.)

(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 [~~subsection~~]; and

(3) (No change.)

(b) Required data elements. CMS has developed claim forms which provide much of the information needed to process claims. Insurance Code

Chapter 1204 identifies two [~~Two~~] of these forms, HCFA 1500 and UB-82/HCFA, and their successor forms, [~~have been identified by Insurance Code Article 21.52C~~] as required for the submission of certain claims. The terms in paragraphs (1) – (4) [~~and (2)~~] of this subsection are based upon the terms CMS used [~~by CMS~~] on successor forms CMS-1500 (08/05), CMS-1500 (12/90), UB-04 CMS-1450, and UB-92 CMS-1450 [~~claim forms~~]. The parenthetical information following each term refers to the applicable CMS claim form[~~,~~] and the field number to which that term corresponds on the CMS claim form. Mandatory form usage dates and optional form transition dates for nonelectronic claims filed or re-filed by physicians or non-institutional providers are set forth in paragraphs (1) and (2) of this subsection. Mandatory form usage dates and optional form transition dates for nonelectronic claims filed or re-filed by institutional providers are set forth in paragraphs (3) and (4) of this subsection.

(1) Required form and data elements for physicians or noninstitutional providers for claims filed or re-filed on or after April 2, 2007. The CMS-1500 (08/05) and the data elements described in this paragraph are required as indicated and must be completed in accordance with the special instructions applicable to the data element for clean claims filed by physicians and noninstitutional providers. Further, upon notification that an HMO or preferred provider carrier is prepared to accept claims filed or re-filed on form CMS-1500 (08/05), a physician or noninstitutional provider may submit claims on

form CMS-1500 (08/05) prior to April 2, 2007, subject to the required data elements set forth in this paragraph.

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

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

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

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

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

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

(G) subscriber's address (street or P.O. Box, city, state, ZIP) (CMS-1500 (08/05), field 7) is required, but physician or provider may enter "same" if the subscriber's address is the same as the patient's address required by subparagraph (E) of this paragraph;

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

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

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

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

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

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

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

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

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

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

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

(i) if answered "yes," then:

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

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

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

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

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

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

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

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

referring primary care physician, specialty physician, or hospital (CMS-1500 (08/05), field 17a);

(W) for claims filed or re-filed on or after May 23, 2007, if there is a referring physician noted in CMS-1500 (08/05), field 17, the physician or provider shall enter the NPI number of the referring primary care physician, specialty physician, or hospital (CMS-1500 (08/05), field 17b) if the referring physician is eligible for an NPI number;

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

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

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

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

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

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

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

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

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

(GG) for claims filed or re-filed on or after May 23, 2007, the NPI number of the rendering physician or provider (CMS-1500 (08/05), field 24J, unshaded portion) is required if the rendering provider is not the billing provider listed in CMS-1500 (08/05), field 33, and if the rendering physician or provider is eligible for an NPI number;

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

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

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

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

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

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

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

(NN) for claims filed or re-filed on or after May 23, 2007, the NPI number of facility where services are rendered (other than home) is required (CMS-1500 (08/05), field 32a) if the facility is eligible for an NPI;

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

(PP) for claims filed or re-filed on or after May 23, 2007, the NPI number of billing provider (CMS-1500 (08/05), field 33a) is required if the billing provider is eligible for an NPI number; and

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

(2)[~~(1)~~] Required form and data elements for physicians or noninstitutional providers for claims filed or re-filed before April 2, 2007. The CMS-1500 (12/90) and the data elements described in this paragraph are

required as indicated and must be completed in accordance with the special instructions applicable to the data element 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 April 2, 2007, subject to the required data elements set forth in subsection (b)(1) of this section.

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

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

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

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

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

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

(G) subscriber's address (street or P.O. Box, city, state, ZIP [~~zip~~]) (CMS-1500 (12/90) [~~CMS 1500~~], 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) [~~CMS 1500~~], 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) [~~(1)(Q)~~] of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof [~~to the HMO or preferred provider carrier~~] 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) [~~CMS 1500~~], 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) [~~(1)(Q)~~] of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof [~~to the HMO or preferred provider carrier~~] 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) [~~CMS 1500~~], 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) [~~(1)(Q)~~] of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof [~~to the HMO or preferred provider carrier~~] 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) [~~CMS 1500~~], 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) [~~(1)(Q)~~] of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof [~~to the HMO or preferred provider carrier~~] 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 [~~facility based~~] radiologist, pathologist or anesthesiologist with no direct patient contact, the physician or provider must either enter the information or enter "NA" [~~NA~~] (not available) if the information is unknown;

(L) other insured's or enrollee's HMO or insurer name (CMS-1500 (12/90) [~~CMS 1500~~], 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) [~~(1)(Q)~~] of this subsection, "disclosure of any other health benefit plans," is answered "yes," this element is required unless the physician or provider submits with the claim documented proof [~~to the HMO or preferred provider carrier~~] 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) [~~CMS 1500~~], field 10) is required, but facility-based [~~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) [~~CMS 1500~~], field 10d);

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

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

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

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

(I) data elements specified in paragraph (2)(H) – (L) [~~(1)(H) - (L)~~] of this subsection are required unless the physician or provider submits with the claim documented proof [~~to the HMO or preferred provider carrier~~] 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) [~~(1)(H) - (L)~~] of this subsection;

(II) the data element specified in paragraph (2)(II) [~~(1)(II)~~] of this subsection is required when submitting claims to secondary payor HMOs or preferred provider carriers;

(ii) if answered "no", [~~respond "no,"~~] the data elements specified in paragraph (2)(H) – (L) [~~(1)(H) - (L)~~] of this subsection are not required if the physician or provider has on file a document signed within the past 12 months by the patient or authorized person stating that there is no other health care coverage; although the submission of the signed document is not a required data element, the physician or provider shall submit a copy of the signed document [~~shall be provided~~] 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) [~~CMS 1500~~], 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) [~~CMS 1500~~], field 13) is required;

(T) date of injury (CMS-1500 (12/90) [~~(HCFA 1500~~], 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); [~~name of referring physician or other source (CMS 1500, field 17) is required for primary care physicians, specialty physicians, and hospitals;~~] 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); [~~I.D. Number of referring physician (CMS 1500], field 17a) is required for primary care physicians, specialty physicians and hospitals;~~] 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) [~~CMS 1500~~], 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) [~~CMS 1500~~], 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) [~~CMS 1500~~], 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) [~~CMS 1500~~], field 23)[~~,~~] is required when prior authorization is required and granted;

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

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

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

(CC) diagnosis code by specific service (CMS-1500 (12/90) [~~CMS 1500~~], 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) [~~CMS 1500~~], field 24F) is required;

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

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

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

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

(II) amount paid (CMS-1500 (12/90) [~~CMS 1500~~], 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) [~~(1)(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) [~~CMS 1500~~], field 31) is required;

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

[~~CMS 1500~~], 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 May 23, 2007. The UB-04 CMS-1450 and the data elements described in this paragraph are required as indicated and must be completed in accordance with the special instructions applicable to the data elements 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, subject to the required data elements set forth in this paragraph, at any time between March 1, 2007 and May 22, 2007.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(CC) for claims filed or re-filed on or after May 23, 2007, the NPI number of the billing provider (UB-04, field 56) is required if the billing provider is eligible for an NPI number;

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

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

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

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

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

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

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

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

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

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

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

(OO) attending physician NPI number (UB-04, field 76) is required on or after May 23, 2007, if attending physician is eligible for an NPI number; and

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

(4) [~~(2)~~] Required form and data elements for institutional providers for claims filed or re-filed before May 23, 2007. The UB-92 CMS-1450 and the data elements described in this paragraph are required as indicated and must be completed in accordance with the special instructions applicable to the data element 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 at any time between March 1, 2007 and May 22, 2007, subject to the required data elements set forth in subsection (b)(3) of this section.

(A) - (E) (No change.)

(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) - (R) (No change.)

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

(T) (No change.)

(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) - (Z) (No change.)

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

(BB) - (EE) (No change.)

(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) (No change.)

(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 [~~(relating to Verification)~~]. If no verification has been provided, treatment authorization codes (UB-92, field 63) are required when authorization is required and granted;

(MM) (No change.)

(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) (No change.)

(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) - (UU) (No change.)

(c) (No change.)

(d) Coordination of benefits or non-duplication of benefits. If a claim is submitted for covered services or benefits in which coordination of benefits pursuant to §§3.3501 - 3.3511 of this title (relating to Group Coordination of Benefits) and §11.511(1) of this title (relating to Optional Provisions) is necessary, the amount paid as a covered claim by the primary plan is a required element of a clean claim for purposes of the secondary plan's processing of the claim and CMS-1500 (08/05), field 29; CMS-1500 (12/90), field 29; ~~[CMS-1500,~~

~~field 29~~] UB-04, field 54; or UB-92, field 54, as applicable, must be completed pursuant to subsection (b)(1)(KK), (2)(II), (3)(BB), [~~(b)(1)(II))~~] and (4)(GG) [~~(b)(2)(GG)~~] of this section. If a claim is submitted for covered services or benefits in which non-duplication of benefits pursuant to §3.3053 of this title (relating to Non-duplication of Benefits Provision) is an issue, the amounts paid as a covered claim by all other valid coverage is a required element of a clean claim and CMS-1500 (08/05), field 29; CMS-1500 (12/90), field 29; [~~CMS 1500, field 29~~] UB-04, field 54; or UB-92, field 54, as applicable, must be completed pursuant to subsection (b)(1)(KK), (2)(II), (3)(BB), [~~(b)(1)(II)~~] and (4)(GG) [~~(b)(2)(GG)~~] of this section. If a claim is submitted for covered services or benefits and the policy contains a variable deductible provision as set forth in §3.3074(a)(4) of this title (relating to Minimum Standards for Major Medical Expense Coverage), the amount paid as a covered claim by all other health insurance coverages, except for amounts paid by individually underwritten and issued hospital confinement indemnity, specified disease, or limited benefit plans of coverage, is a required element of a clean claim and CMS-1500 (08/05), field 29; CMS-1500 (12/90), field 29; [~~CMS 1500, field 29~~] UB-04, field 54; or UB-92, field 54, as applicable, must be completed pursuant to subsection (b)(1)(KK), (2)(II), (3)(BB), [~~(b)(1)(II)~~] and (4)(GG) [~~(b)(2)(GG)~~] of this section. Notwithstanding these requirements, an HMO or preferred provider carrier may not require a physician or provider to investigate coordination of other health benefit plan coverage.

(e) - (h) (No change.)

8. CERTIFICATION. This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on _____, 2007.

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