STANDARDIZED HEALTH CLAIM FORM MODEL REGULATION

Table of Contents

Drafting Note: This regulation is for use by states that have current statutory authority to prescribe a standard claim form for the filing of health care claims. It assumes the authority is broad enough to require compliance by the health care practitioner community. States that do not have this broad authority should delete the requirements that apply to providers.

Section 1. Short Title

This regulation shall be known and may be cited as the Standardized Health Claim Form Regulation.

Section 2. Purpose

The purpose and intent of this regulation is to standardize the forms used in the billing and reimbursement of health care, reduce the number of forms utilized, increase efficiency in the reimbursement of health care through standardization and encourage the use of and prescribe a timetable for implementation of electronic data interchange of health care expenses and reimbursement.

Section 3. Definitions

As used in this regulation:

A. "ASC X12N standard format" means the standards for electronic data interchange within the health care industry developed by the Accredited Standards Committee X12N Insurance Subcommittee of the American National Standards Institute.

B. "CDT-1 Codes" means the current dental terminology prescribed by the American Dental Association.

C. "CPT-4 Codes" means the physicians current procedural terminology, fourth edition published by the American Medical Association.

D. "HCFA" means the Health Care Financing Administration of the U.S. Department of Health and Human Services.

E. "HCFA Form 1450" means the health insurance claim form maintained by HCFA for use by institutional care practitioners.

F. "HCFA Form 1500" means the health insurance claim form maintained by HCFA for use by health care practitioners.

G. "HCPCS" means HCFA's Common Procedure Coding System, a coding system which describes products, supplies, procedures and health professional services and includes, the American Medical Association's (AMA's) Physician Current Procedural Terminology, Fourth Edition (CPT-4) codes, alphanumeric codes, and related modifiers. This includes:

(1) "HCPCS Level 1 Codes" which are the AMA's CPT-4 codes and modifiers for professional services and procedures.

(2) "HCPCS Level 2 Codes" which are national alpha-numeric codes and modifiers for health care products and supplies, as well as some codes for professional services not included in the AMA's CPT-4.

(3) "HCPCS Level 3 Codes" which are local alpha-numeric codes and modifiers for items and services not included in HCPCS Level 1 or HCPCS Level 2.

H. "Health care practitioner" means:

(1) An acupuncturist licensed under [insert state statute defining an acupuncturist].

(2) A chiropractor licensed under [insert state statute defining a chiropractor].

(3) A corporation or partnership of health care practitioners defined in this section.

(4) A dentist licensed under [insert state statute defining a dentist].

(5) A nurse licensed under [insert state statute defining each level of nursing (i.e. registered nurse, licensed practical nurse)].

(6) An ophthalmologist licensed under [insert state statute defining an ophthalmologist].

(7) An optometrist licensed under [insert state statute defining an optometrist].

(8) A physician licensed under [insert state statute defining a physician].

(9) A podiatrist licensed under [insert state statute defining a podiatrist].

(10) A psychologist licensed under [insert state statute defining a psychologist].

(11) A speech, physical, respiratory or occupational therapist licensed under [insert state statutes defining speech, physical, respiratory and occupational therapists].

(12) A home health care provider [insert state statute defining home health care providers].

Drafting Note: States are encouraged to consult with the state agency responsible for licensing health care practitioners to be certain all practitioners of health care licensed by the state are included in this section.

I. "ICD-9-CM Codes" means the diagnosis and procedure codes in the International Classification of Diseases, Ninth revision, clinical modifications published by the U.S. Department of Health and Human Services.

J. "Institutional Care Practitioner" means:

(1) A hospice licensed under [insert state statute defining a hospice];

(2) A hospital licensed under [insert state statute defining a hospital]; and

(3) Skilled nursing facility, extended care facility, intermediate care facility, convalescent nursing home, and personal care facility licensed under [insert state statute defining long-term care related facilities].

Drafting Note: States are encouraged to consult with the state agency responsible for licensing institutional care practitioners to be certain all institutional providers of health care licensed by the state are included in this section.

K. "Issuer" means an insurance company, fraternal benefit society, health care service plan, health maintenance organization, and third party administrator, and any other entity reimbursing the costs of health care expenses.

Drafting Note: States that do not regulate third party administrators should delete the reference to them from this section.

L. "J512 Form" means the uniform dental claim form approved by the American Dental Association for use by dentists.

M. "Revenue Codes" means the codes established for use by institutional care practitioners by the National Uniform Billing Committee.

Drafting Note: The U.S. Government Printing Office, 710 North Capitol Street NW, Washington, DC 20401 can supply copies of the following: HCPCS Codes, ICD-9-CM Diagnosis Codes, Volumes 1 & 2, HCFA Form 1450 and instructions, HCFA Form 1500 and instructions. The American Dental Association, 211 East Chicago Ave., Chicago, IL 60611 can supply the CDT-1 Codes and users manual and the J512 Form. The American Medical Association Form Order Department can supply copies of the Physician's Current Procedural Terminology (CPT-4) book.

Section 4. Applicability and Scope

A. Except as otherwise specifically provided, the requirements of this regulation apply to issuers, health care practitioners, and institutional care practitioners.

B. Nothing in this regulation shall prevent an issuer from requesting additional information that is not contained on the forms required under this regulation to determine eligibility of the claim for payment if required under the terms of the policy or certificate issued to the claimant.

C. Nothing in this regulation shall prohibit an issuer, health care practitioner or institutional care practitioner from using alternative forms or procedures for filing claims as are specified in a written contract between the health care practitioner or institutional care practitioner and issuer.

Drafting Note: A contract under Subsection C cannot relieve a health care practitioner, institutional care practitioner or issuer from data reporting requirements under state or federal law or regulation.

Section 5. Requirements for Use of HCFA Form 1500

A. Health care practitioners, other than dentists, shall use the HCFA Form 1500 and instructions provided by HCFA for use of the HCFA Form 1500 when filing claims with issuers for professional services. Health care practitioners that bill patients directly shall provide a properly completed HCFA Form 1500 in addition to any other explanatory information used to bill the patient when requested by the patient.

B. Issuers may only require health care practitioners to use the following coding system for the initial filing of claims for health care services:

(1) HCPCS Codes; and

(2) ICD-9-CM Codes.

C. Issuers may only require health care practitioners to use other explanations with a code or to furnish additional information with the initial submission of a HCFA Form 1500 under the following circumstances:

(1) When the procedure code used describes a treatment or service that is not otherwise classified; or

(2) When the procedure code is followed by the CPT-4 modifier 22, 52 or 99. Health care practitioners may use item 19 of the HCFA Form 1500 to explain multiple modifiers, unless item 19 is used for other purposes in accordance with the instructions for this form.

D. Health care practitioners may use Box 19 of the HCFA Form 1500 to indicate the form is an amended version of a form previously submitted to the issuer by inserting the word "amended" in the space provided.

E. Health care practitioners billing for services based on the amount of time involved shall define on line 19 the time interval in item 24 G of the HCFA Form 1500, if the time interval is not already defined the HCPCS code. If not defined by either HCPCS or in line 19, units will be assumed to be days of treatment.

F. Health care practitioners shall provide the unique physician identification number, as assigned by HCFA, in box 17a and the federal tax identification number or social security number to complete Item 25 of the HCFA Form 1500, as required by the HCFA instructions.

Section 6. Requirements for Use of HCFA Form 1450

A. Institutional care practitioners shall use the HCFA Form 1450 and instructions provided by HCFA for use of the HCFA Form 1450 when filing claims with issuers for health care services. Institutional care providers that bill patients directly shall provide a properly completed HCFA Form 1450 in addition to any other explanation information used to bill the patient when requested by the patient.

B. Issuers may only require institutional care practitioners to use the following coding system for the initial filing of claims for health care services:

(1) ICD-9-CM Codes;

(2) Revenue Codes;

(3) HCPCS Codes; and

(4) The information outlined in Section 5 of this regulation, if the charges include direct service furnished by a health care practitioner, and the direct service are not covered by the instructions for the HCFA form 1450.

C. Hospitals may use the HCFA Form 1500 to supplement a HCFA Form 1450 if necessary in billing patients or their representatives or filing claims with issuers for outpatient services.

Section 7. Requirements for Use of J512 Form

A. Dentists shall use the J512 Form and instructions provided by the American Dental Association CDT-1 for use of the J512 Form for filing claims with issuers for professional services. Dentists that bill patients directly shall provide a properly completed J512 Form in addition to any other form used to bill the patient when requested by the patient.

B. Issuers may not require a dentist to use any code other than the CDT-1 codes for the initial filing of claims for dental care services, unless the use of supplemental codes are defined and permitted in a written contract between the issuer and dentist.

Section 8. General Provisions

A. Health care practitioners and institutional care practitioners shall file claims in a manner consistent with the requirements of this regulation. Claims filed in paper form shall be printed on 8.5 x 11 inch paper.

B. Issuers shall accept forms submitted in compliance with this regulation for the processing of claims.

C. Health care practitioners, institutional care practitioners and issuers shall:

(1) Use and accept the most current editions of the HCFA Form 1500, HCFA Form 1450, or J512 Form and most current instructions for these forms in the billing of patients or their representatives and filing claims with issuers.

(2) Modify their billing and claim reimbursement practices to encompass the coding changes for all billing and claim filing by the effective date of the changes set forth by the developers of the forms, codes and procedures required under this regulation.

Section 9. Mandatory Electronic Format

Issuers that receive claims or send payments by electronic means shall, by [insert date] or the date on which the Health Care Financing Administration requires it of Medicare intermediaries and carriers, whichever is later, accept the ASC X12N standard format for the health care claims submission transaction set (837) and send the ASC X12N health care claim payment transaction set (835).

Section 10. Separability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected thereby.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1993 Proc. 4th Quarter 16, 18, 660, 664-668 (adopted).