STANDARDIZED HEALTH CLAIM FORM MODEL REGULATION

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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).

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This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama		ALA. CODE § 27-1-16 (1981/1993).
Alaska		ALASKA ADMIN. CODE tit. 3, §§ 28.700 to 28.725 (1995).
American Samoa	NO CURRENT ACTIVITY	
Arizona	NO CURRENT ACTIVITY	
Arkansas		ARK. CODE ANN. § 23-85-136 (1987/2001); § 23-86-117 (1987).
California	NO CURRENT ACTIVITY	
Colorado		COLO. REV. STAT. § 10-1-131 (1993); § 10-16-106.3 (2002).
Connecticut		CONN. GEN. STAT. § 38a-477 (1993/2003).
Delaware	NO CURRENT ACTIVITY	
District of Columbia		D.C. CODE ANN. § 31-3201 (1995).
Florida		FLA. STAT. § 627.647 (1988/2003); § 408.7071 (1993); FLA. ADMIN. CODE ANN. r. 69O-161.001 to 69O-161.009 (1994).
Georgia		GA. CODE ANN. § 33-24-10.1 (1992); GA. COMP. R. REGS. 120-2-59 (1994/1999).
Guam	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Hawaii	NO CURRENT ACTIVITY	
Idaho	IDAHO ADMIN. CODE 18.01.71 (1995) (portions of model).	
Illinois		ILL. ADMIN. CODE tit. 50, §§ 2017.10 to 2017.70 (1994/1996).
Indiana		IND. CODE § 27-8-5.5-2 (1990); 760 IND. ADMIN. CODE 1-23 (1988/2013).
Iowa	NO CURRENT ACTIVITY	
Kansas		KAN. STAT. ANN. § 40-2253 (1991/1992); KAN. ADMIN. REGS. § 40-4-40 (1993).
Kentucky		KY. REV. STAT. ANN. § 304.14-135 (1980/2000); 806 KY. ADMIN. REGS 17:370 (2003/2008).
Louisiana		LA. REV. STAT. ANN. § 22:982 (1993/2003); § 22:466 (1990/2009); LA. ADMIN. CODE 37:XIII.2301 to 37:XIII.2313 (Regulation 48) (1994).
Maine		ME. REV. STAT. ANN. tit. 24, § 2332-E (1985/2003); § 2985 (1993); tit. 24-A, § 1912 (1993/2005); § 2680 (1993/2003); § 2753 (1993/2005) § 2823-B (1993/2005); § 4235 (1993/2005); 02-031 ME. CODE R. § 1 to 6 (2005).
Maryland	MD. CODE REGS. §§ 31.10.11.01 to 31.10.11.14 (1993/2003).	MD. CODE ANN., INS. §§ 15-1002 to 15-1004 (1980/2005); § 1508 (1993).
Massachusetts	NO CURRENT ACTIVITY	
Michigan	NO CURRENT ACTIVITY	
Minnesota		MINN. STAT. § 62J.50 to 62J.61 (1994/2008).
Mississippi		MISS. CODE ANN. § 83-9-13 (1985/1993).
Missouri		MO. REV. STAT. § 374.184 (1992); MO. CODE REGS. ANN. tit. 20, § 400.8.300 (1995).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Montana	MONT. ADMIN. R. 6.6.5501 to 6.6.5515 (1995).	
Nebraska	NO CURRENT ACTIVITY	
Nevada		NEV. REV. STAT. § 679B.138 (1999/2001) (Authority to adopt regulations); § 689A.105 (1975); § 689B.250 (1975); NEV. ADMIN. CODE §§ 689A.310 to 689A.350 (1976/2009).
New Hampshire		N.H. REV. STAT. ANN. § 400-A:15-a (1993/1996); N.H. CODE R. INS. 4001.01 to 4007.01 (2005).
New Jersey		N.J. ADMIN. CODE §§ 11:22-3.1 to 11:22-3.11 (2001/2006); BULLETIN 2009-5 (2009).
New Mexico	N.M. CODE R. § 13.10.12.7 (1994/2001).	N.M. STAT. ANN. § 59A-18-27.1 (1993); O.G.C. 10-25-2006 (2006).
New York		N.Y. INS. LAW § 3224 (1984); N.Y. COMP. CODES R. & REGS. tit. 11, §§ 17.0 to 17.6 (1979/1981); O.G.C. 11-10-2006 (2006).
North Carolina		N.C. GEN. STAT. §§ 58-3-171 to 58-3-172 (2008); 11 N.C. ADMIN. CODE §§ .1501 to .1509 (1994/1995).
North Dakota	N.D. ADMIN. CODE §§ 45-06-03.1-01 to 45-06-03.1-03 (1994).	N.D. CENT. CODE § 26.1-36-37.1 (1985/1993).
Northern Marianas	NO CURRENT ACTIVITY	
Ohio	OHIO ADMIN. CODE § 3901-1-59 (1994).	OHIO REV. CODE ANN. §§ 3902.21 to 3902.23 (1992).
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-30 to 365:10-36 (1994).	OKLA. STAT. tit. 36, § 6581 (1993); OKLA. ADMIN. CODE § 365:10-1-3 (1985/1991).
Oregon		OR. ADMIN. R. 836-050-0110 (1977/1995).
Pennsylvania		40 PA. STAT. ANN. § 39.802 (1992).
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
South Carolina	NO CURRENT ACTIVITY	
South Dakota	S.D. ADMIN. R. 20:06:27 (1995).	S.D. CODIFIED LAWS §§ 58-12-12 to 58-12-14 (1994).
Tennessee		TENN. CODE ANN. § 56-7-1008 (1980); § 56-1-104 (1993); TENN. COMP. R. & REGS. 0780-1-20-.09 (1984).
Texas		28 TEX. ADMIN. CODE §§ 21.2801 to 21.2826 (2000/2014).
Utah		UTAH CODE ANN. § 31A-22-614.5 (1993/2008); § 31A-22-614.7 (2013).
Vermont	VT. CODE R. § 93-4 (1993).	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia		VA. CODE ANN. § 38.2-322 (1993/1994).
Washington		BULLETIN 78-4 (1978); BULLETIN 78-10 (1978); BULLETIN 84-5 (1984).
West Virginia	NO CURRENT ACTIVITY	
Wisconsin	WIS. ADMIN. CODE § 3.65 (1993).	WIS. STAT. § 601.41 (2002/2013); § 610.65 (1977/2009); WIS. ADMIN. CODE § INS. 3.60 (1992/1993); § 3.651 (1993).
Wyoming	51 WYO. CODE R. §§ 1 to 10 (1997).	

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Cited to the Proceedings of the NAIC

A commissioner reported that several states are required to implement a standard claims form and suggested the NAIC address the issue. Another regulator requested that the NAIC get involved in a federal task force's work on electronic claims filing. **1992 Proc. IIB 673**.

A regulator reported his state recently held a hearing on a standardized claim form rule and said the provider community and consumer groups strongly supported the rule. The insurance industry was generally supportive. He indicated his state's rule required the use of widely accepted Health Care Financing Administration forms. **1993 Proc. IB 818**.

Section 1. Short Title

The drafters discussed whether to develop a model act or regulation and decided a model regulation was appropriate. **1993 Proc. 2nd Quarter 743**.

Section 2. Purpose

Section 3. Definitions

H. Near the end of the drafting process, the working group heard a comment that a "health care practitioner" did not include a home health care provider. The working group included a home health care provider in the list of health care practitioners and adding a drafting note encompassing any other providers. **1993 Proc. 3rd Quarter 452**.

K. The drafters decided to include a definition of "issuer" to be inclusive of all persons involved with reimbursement of health care costs. **1993 Proc. 2nd Quarter 742**.

Section 4. Applicability and Scope

An interested party asked why pharmaceutical claims were not included in the provisions of the model. The chair indicated that the working group had not intentionally excluded pharmacies, but had not discussed the issue. A regulator informed the group that pharmacies currently use a procedure that is far more interactive and advanced than the proposals in the model or those from the Working Group on Electronic Data Interchange. **1993 Proc. 2nd Quarter 742**.

B. A provision that permits an insurer to request additional information was placed in Section 4 so it was applicable to all the forms required by the model. **1993 Proc. 2nd Quarter 742.**

C. A provision that exempts an issuer from requirements of the act if a contract between the issue and practitioner specifies different requirements was placed in Section 4 so it was applicable to all the forms required by the model. **1993 Proc. 2nd Quarter 742.**

One comment on the model draft indicated a concern on the applicability of the regulation to health maintenance organizations that do not use a claim-based payment mechanism. The chair indicated that Section 4C exempts issuers from the requirements of the regulation if there is a written contract between the issuer and a provider with alternative procedures. **1993 Proc. 3rd Quarter 451.**

Section 5. Requirements for Use of HCFA Form 1500

C. Interested parties commented that the HCFA Form 1500 (standardized claim for physician's services) no longer contains a narrative description of the services rendered. This makes it difficult for consumers to cross-check the bills from providers with the services they receive. The working group decided that this point should be made to the Health Care Financing Administration for consideration when the forms are revised. **1993 Proc. 2nd Quarter 744.**

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Section 6. Requirements for Use of HCFA Form 1450

Section 7. Requirements for Use of J512 Form

An attorney expressed concern about the use of the American Dental Association (ADA) form and coding system. The chair expressed concern about the proprietary nature of the data and the manner in which the ADA had responded to use of its forms and coding system. An interested party commented that a council on dental standards was developing a form and coding system to use with dental claims. The working group decided to explore with the ADA the acceptability of using the ADA form and coding system as an open non-proprietary standard for reference in the model. **1993 Proc. 2nd Quarter 743.**

At a later meeting the chair reported that the ADA had promptly responded to the request from the working group and he believed all concerns had been resolved. **1993 Proc. 3rd Quarter 452**.

A meeting attendee expressed concern over the use of the ADA forms and said the Health Care Financing Administration (HCFA) should devise the forms instead of the ADA. The working group concluded the ADA's forms and coding were the best standards available and that HCFA does not have and does not plan to develop a dental form. **1993 Proc. 3rd Quarter 448.**

Section 8. General Provisions

C. The drafters decided to include a provision in the model to permit revisions to the prescribed forms without revising the model or state statute. **1993 Proc. 2nd Quarter 743**.

Section 9. Mandatory Electronic Format

A federal regulator said his agency pays 40% of the nation's health care expenses and 70% of its claims are filed electronically. He said the agency had seen a significant reduction in administration costs as a result of increased electronic claims filing. **1993 Proc. IB 818**.

The working group drafting the NAIC model considered a recommendation to specifically include a requirement for electronic data interchange on medical claims. **1993 Proc. 1st Quarter 269.**

A federal regulator said the Health Care Financing Administration was in the process of converting its electronic claims processing system to the ANSI-837 standards. **1993 Proc. 1st Quarter 269**.

The drafters anticipated a report from the Working Group on Electronic Data Interchange (WEDI) that would contain detailed specifications on electronic format for submissions of claims data. The report was delayed and a representative said he thought it would not contain specific language relative to electronic transmission of claims data. **1993 Proc. 2nd Quarter 742**.

Because the WEDI report was not completed, the working group agreed to delete a requirement to file claims electronically. The regulators agreed to revisit the issue once specific standards for electronic transmission of claims data were available. **1993 Proc. 2nd Quarter 743.**

The chair reaffirmed that the working group fully intended that draft regulation would be consistent with the WEDI efforts. An update on the WEDI report indicated it would recommend use of the ANSI X12 standard format for the four core health care transaction sets. The provider community was reported to be split on the implementation of the WEDI recommendations and some providers believed it should be optional rather than mandatory. The chair suggested it would be inappropriate for the working group to take a position on the content of the fields in the standard form unless there were clear guidelines or a consensus among users of the forms. **1993 Proc. 3rd Quarter 451-452.**

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Section 9 (cont.)

At the next NAIC meeting an attendee said that the WEDI report had been released and that it contained unique identifiers for patients, providers and payers and had standards for health identification cards. WEDI thought federal preemptive language was needed to promote the use of electronic data interchange. The chair asked if the draft model was consistent with the WEDI report and the attendee responded that it was. **1993 Proc. 4th Quarter 664.**

Section 10. Separability

Chronological Summary of Action

March 1994: Adopted model.

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