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TITLE 28	INSURANCE
PART 1	TEXAS DEPARTMENT OF INSURANCE
CHAPTER 21	TRADE PRACTICES
SUBCHAPTER T	SUBMISSION OF CLEAN CLAIMS
RULE §21.2803	Elements of a Clean Claim

(a) Required clean claim elements. A physician or provider submits a clean claim by providing the required data elements specified in subsection (b) of this section to an HMO or a preferred provider carrier, along with any attachments and additional elements, or revisions to data elements, attachments and additional elements, of which the physician or provider has been properly notified as necessary pursuant to subsections (c) and (d) of this section, and §§21.2804 of this title (relating to Disclosure of Necessary Attachments), 21.2805 of this title (relating to Disclosure of Additional Clean Claim Elements), and 21.2806 of this title (relating to Disclosure of Revision of Data Elements, Attachments, or Additional Clean Claim Elements), and any coordination of benefits or non-duplication of benefits information pursuant to subsection (e) of this section, if applicable.

(b) Required data elements. HCFA has developed claim forms which provide much of the information needed to process claims. 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 used in paragraphs (1), (2) and (3) of this subsection are based upon the terms used by HCFA on successor forms HCFA-1500 (12-90) and UB-92 HCFA-1450 claim forms. The parenthetical information following each term is a reference to the applicable HCFA claim form, and the field number to which that term corresponds on the HCFA claim form.

(1) Essential data elements for physicians or noninstitutional providers. Unless otherwise agreed by contract, the data elements described in this paragraph are necessary for claims filed by physicians and noninstitutional providers.

(A) subscriber's/pafenfs plan ID number (HCFA 1500, field la);

(B) patient's name (HCFA 1500, field 2);

(C) patient's date of birth and gender (HCFA 1500, field 3);

(D) subscriber's name (HCFA 1500, field 4);

(E) patient's address (street or P.O. Box, city, zip) (HCFA 1500, field 5);

(F) patient's relationship to subscriber (HCFA 1500, field 6);

(G) subscriber's address (street or P.O. Box, city, zip) (HCFA 1500, field 7);

(H) whether patient's condition is related to employment, auto accident, or other accident (HCFA 1500, field 10);

(1) subscriber's policy number (HCFA 1500, field 11);

(J) subscriber's birth date and gender (HCFA 1500, field 11 a);

(K) HMO or preferred provider carrier name (HCFA 1500, field l lc);

(L) disclosure of any other health benefit plans (HCFA 1500, field l ld);

(i) if respond "yes", then

(1) data elements specified in paragraph (3)(A) - (E) of this subsection are essential 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 (3)(A) - (E) of this subsection;

(11) the data element specified in paragraph (3)(1) of this subsection is essential when submitting claims to secondary payor HMOs or preferred provider carriers;

(ii) if respond "no," the data elements specified in paragraph (3)(A) - (E) of this subsection are not applicable and therefore are not considered essential 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 an essential data element, a copy of the signed document shall be provided to the HMO or preferred provider carrier upon request.

(M) patient's or authorized person's signature or notation that the signature is on file with the physician or provider (HCFA 1500, field 12);

(N) subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider (HCFA 1500, field 13);

(O) date of current illness, injury, or pregnancy (HCFA 1500, field 14);

(P) first date of previous same or similar illness (HCFA 1500, field 15);

(Q diagnosis codes or nature of illness or injury (HCFA 1500, field 21);

(R) date(s) of service (HCFA 1500, field 24A);

(S) place of service codes (HCFA 1500, field 24B);

(T) type of service code (HCFA 1500, field 24C);

(U) procedure/modifier code (HCFA 1500, field 24D);

(V) diagnosis code by specific service (HCFA 1500, field 24E);

(W) charge for each listed service (HCFA 1500, field 24F);

(Q revenue code (UB-92, field 42);

(R) revenue description (UB-92, field 43);

(S) units of service (UB-92, field 46);

(T) total charge (UB-92, field 47);

(U) HMO or preferred provider carrier name (UB-92, field 50);

(V) subscriber's name (UB-92, field 58);

(W) patient's relationship to subscriber (UB-92, field 59);

(X) patient's/subscriber's certificate number, health claim number, ID number (UB-92, field 60);

(Y) principal diagnosis code (UB-92, field 67);

(Z) attending physician ID (UB-92, field 82);

(AA) signature of provider representative or notation that the signature is on file with the HMO or preferred provider carrier (UB-92, field 85); and

(BB) date bill submitted (UB-92, field 86).

(3) Data elements that are necessary, if applicable. Unless otherwise agreed by contract, the data elements contained in this paragraph are necessary for claims filed by physicians or providers if circumstances exist which render the data elements applicable to the specific claim being filed. The applicability of any given data element contained in this paragraph is determined by the situation from which the claim arose.

(A) other insured s~or enrollee's name (HCFA 1500, field 9), is applicable if patient is covered by more than one health benefit plan, generally in situations described in subsection (e) of this section. If the essential data element specified in paragraph (1)(L) of this subsection, "disclosure of any other health benefit plans", is answered yes, this is applicable 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;

(B) other insured's or enrollee's policy/group number (HCFA 1500, field 9a), is applicable if patient is covered by more than one health benefit plan, generally in situations described in subsection (e) of this section. If the essential data element specified in paragraph (1)(L) of this subsection, "disclosure of any other health benefit plans," is answered yes, this is applicable 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;

(C) other insured's or enrollee's date of birth (HCFA 1500, field 9b), is applicable if patient is covered by more than one health benefit plan, generally in situations described in subsection (e) of this section.

If the essential data element specified in paragraph (1)(L) of this subsection, "disclosure of any other health benefit plans," is answered yes, this is applicable 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;

(D) other insured's or enrollee's plan name (employer, school, etc.) (HCFA 1500, field 9c), is applicable if patient is covered by more than one health benefit plan, generally in situations described in subsection (e) of this section. If the essential data element specified in paragraph (1)(L) of this subsection, "disclosure of any other health benefit plans", is answered yes, this is applicable 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;

(E) other insured's or enrollee's HMO or insurer name (HCFA 1500, field 9d), is applicable if patient is covered by more than one health benefit plan, generally in situations described in subsection (e) of this section. If the essential data element specified in paragraph (1)(L) of this subsection, "disclosure of any other health benefit plans," is answered yes, this is applicable 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;

(F) subscriber's plan name (employer, school, etc.) (HCFA 1500, field 1 lb) is applicable if the health benefit plan is a group plan;

(G) prior authorization number (HCFA 1500, field 23), is applicable when prior authorization is required;

(H) whether assignment was accepted (HCFA 1500, field 27), is applicable when assignment under Medicare has been accepted;

(1) amount paid (HCFA 1500, field 29), is applicable 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)(L) of this subsection and as required by subsection (e) of this section;

(J) balance due (HCFA 1500, field 30), is applicable 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;

(K) covered days (UB-92, field 7), is applicable if Medicare is a primary or secondary payor;

(L) noncovered days (UB-92, field 8), is applicable if Medicare is a primary or secondary payor;

(M) coinsurance days (UB-92, field 9), is applicable if Medicare is a primary or secondary payor;

(N) lifetime reserve days (UB-92, field 10), is applicable if Medicare is a primary or secondary payor, and the patient was an inpatient;

(O) discharge hour (UB-92, field 21), is applicable if the patient was an inpatient, or was admitted for

outpatient observation;

(P) condition codes (UB-92, fields 24-30), are applicable if the HCFA UB-92 manual contains a condition code appropriate to the patient's condition;

(Q occurrence codes and dates (UB-92, fields 31-36), are applicable if the HCFA UB-92 manual contains an occurrence code appropriate to the patient's condition;

(R) occurrence span code, from and through dates (UB-92, field 36), is applicable if the HCFA UB-92 manual contains an occurrence span code appropriate to the patient's condition;

(S) HCPCS/Rates (UB-92, field 44), is applicable if Medicare is a primary or secondary payor;

(T) prior payments--payor and patient (UB-92, field 54), is applicable 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 (e) of this section;

(U) diagnoses codes other than principle diagnosis code (UB-92, fields 68-75), is applicable if there are diagnoses other than the principle diagnosis;

(V) procedure coding methods used (UB-92, field 79), is applicable if the HCFA UB-92 manual indicates a procedural coding method appropriate to the patient's condition;

(W) principal procedure code (UB-92, field 80), is applicable if the patient has undergone an inpatient or outpatient surgical procedure; and

(X) other procedure codes (UB-92, field 81), is applicable as an extension of subparagraph (W) of this paragraph if additional surgical procedures were performed.

(c) Attachments. In addition to the required data elements set forth in subsection (b) of this section, HCFA has developed a variety of manuals that identify various attachments required of different physicians or providers for specific services. An HMO or a preferred provider carrier may use the appropriate Medicare standards for attachments in order to properly process claims for certain types of services. An HMO or a preferred provider carrier may only require as attachments information that is either contained in or in the process of being incorporated into a patient's medical or billing record maintained by the physician or provider. Before any attachments may be required, the HMO or preferred provider carrier shall satisfy the notification procedures set forth in §21.2804 of this title (relating to Disclosure of Necessary Attachments).

(d) Additional clean claim elements. Additional elements beyond the required data elements and attachments identified in subsections (b) and (c) of this section may be required. Before any additional clean claim elements may be required, the HMO or the preferred provider carrier shall satisfy the notification procedures set forth in §21.2805 of this title (relating to Disclosure of Additional Clean Claim Elements). An HMO or a preferred provider carrier may only require as additional clean claim elements information that is either contained in or in the process of being incorporated into a patient's medical or billing record maintained by the physician or provider.

(e) 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