PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R026-12

March 27, 2012

EXPLANATION – Matter in ***italics*** is new; matter in brackets [~~omitted material~~] is material to be omitted.

AUTHORITY: §1, NRS 679B.130 and 686A.015; §§2 and 3, NRS 679B.130, 679B.138 and 686A.015; §4, NRS 679B.130.

A REGULATION relating to insurance; prescribing the form which must be used for the submission of certain claims; repealing certain provisions relating to the submission of certain information for an insurance claim; and providing other matters properly relating thereto.

Section 1. NAC 686A.282 is hereby amended to read as follows:

686A.282 A "clean claim" means a claim:

1. That contains the [~~required~~] information [~~pursuant to NAC 686A.292, 686A.294 and 686A.296 or 686A.298, 686A.300 and 686A.302;~~] ***required to be included for the applicable use of a form prescribed in NAC 686A.288;*** and

2. For which any additional information that has been requested pursuant to subsection 2 of NRS 683A.0879, 689A.410, 689B.255, 689C.485, 695B.2505 or 695C.185 because of any particular or unusual circumstances that would have impeded the payer from paying the claim has been received.

Sec. 2. NAC 686A.288 is hereby amended to read as follows:

686A.288 1. The payer of a claim under a contract for health insurance:

(a) Shall accept a claim submitted on a form that:

(1) Has been approved by the United States Department of Health and Human Services for the filing of a claim under a contract for health insurance; and

(2) Contains the information necessary to constitute a clean claim.

(b) Shall not require the completion of any other form for the purpose of processing the claim.

2. For the purposes of this section, a "form that has been approved by the United States Department of Health and Human Services" means:

(a) For claims submitted by a hospital or other institutional provider, ~~[Health Care Financing Administration (HCFA)]~~ ***Centers for Medicare and Medicaid Services*** Form ~~[1450,]~~ ***CMS-1450,*** which is commonly referred to as ~~[UB 92 (formerly UB 82),]~~ ***UB-04,*** or its successor form; and

(b) For claims submitted by a health care practitioner or other person entitled to reimbursement, ~~[Health Care Financing Administration (HCFA)]~~ ***Centers for Medicare and Medicaid Services*** Form ~~[1500,]~~ ***CMS-1500,*** or its successor form.

3. ~~[Health Care Financing Administration (HCFA) Form 1450 and Health Care Financing Administration (HCFA) Form 1500 are hereby adopted by reference. A copy of HCFA Form 1450 or HCFA Form 1500 may be obtained on the Internet, free of charge, at . Copies of HCFA Form 1500 may also be obtained by mail from the Superintendent of Documents, U.S. Government Printing Office, P.O. Box 979050, St. Louis, Missouri 63197-9000, or by toll-free telephone at (866) 512-1800, for the price of $16 for a package of 100.]~~ ***Form CMS-1450, also known as the UB-04 claim form, published by the National Uniform Billing Committee, is available from the American Hospital Association on the Internet at http://aha.org/, by telephone at (800) 242-2626, or by mail at 155 North Wacker Drive, Chicago, Illinois 60606,***

at the price of $46 for members and $56 for nonmembers. Copies of the form may also be available through office supply stores.

4. Form CMS-1500, published by the National Uniform Claim Committee, is available from the United State Government Printing Office on the Internet website http://bookstore.gpo.gov, by mail at P.O. Box 979050, St. Louis, Missouri 63197-9000, or by toll-free telephone at (866) 512-1800, at the price of $29. Copies of the form may also be available through local printing companies and office supply stores.

Sec. 3. NAC 686A.302 is hereby amended to read as follows:

686A.302 1. A payer shall not use or require a hospital or other institutional provider to use any field for purposes that are inconsistent with the data required ~~[pursuant to NAC 686A.298 and 686A.300,]~~ ***for the submission of a clean claim,*** or in addition to the applicable standard code set.

2. A hospital or other institutional provider may elect to include data in addition to the data required ~~[pursuant to NAC 686A.298 and 686A.300.]~~ ***for the submission of a clean claim.***

Sec. 4. NAC 686A.292, 686A.294, 686A.296, 686A.298, 686A.300 and 689A.431 are hereby repealed.

TEXT OF REPEALED SECTIONS

686A.292 Claim by health care practitioner or other person entitled to reimbursement: Required form and data. (NRS 679B.130, 679B.136, 679B.138, 686A.015) A claim form

submitted by a health care practitioner or other person entitled to reimbursement must be submitted on Health Care Financing Administration (HCFA) Form 1500 and must include the following data:

1. Subscriber's plan ID number (HCFA Form 1500, field 1a);

2. Patient's name (HCFA Form 1500, field 2);

3. Patient's date of birth and gender (HCFA Form 1500, field 3);

4. Subscriber's name (HCFA Form 1500, field 4);

5. Patient's address, including the street or post office box, city and zip code (HCFA Form 1500, field 5);

6. Patient's relationship to the subscriber (HCFA Form 1500, field 6);

7. Subscriber's address, including the street or post office box, city and zip code (HCFA Form 1500, field 7);

8. Whether the patient's condition is related to:

(a) Employment (HCFA Form 1500, field 10a);

(b) An auto accident (HCFA Form 1500, field 10b); or

(c) An accident other than an auto accident (HCFA Form 1500, field 10c);

9. Subscriber's policy number (HCFA Form 1500, field 11);

10. Except in the case of a laboratory that has been issued a license pursuant to chapter 652 of NRS:

(a) The patient's status (HCFA Form 1500, field 8);

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

(c) The name of the payer (HCFA Form 1500, field 11c);

(d) Whether the patient has had the same or a similar illness (HCFA Form 1500, field 15); and

(e) The date of the current illness, injury or pregnancy (HCFA Form 1500, field 14);

11. Disclosure of any other health benefit plans (HCFA Form 1500, field 11d);

12. Patient's or authorized person's signature or notation that the signature is on file with the health care practitioner (HCFA Form 1500, field 12);

13. Subscriber's or authorized person's signature or notation that the signature is on file with the health care practitioner or other person entitled to reimbursement, if applicable (HCFA Form 1500, field 13);

14. Except in the case of a health care practitioner for emergency services:

(a) Whether the patient has had the same or a similar illness (HCFA Form 1500, field 15); and

(b) The name of the referring physician or health maintenance organization (HCFA Form 1500, field 17);

15. Hospitalization dates related to current services, if applicable (HCFA Form 1500, field 18);

16. Diagnosis codes or nature of the illness or injury (HCFA Form 1500, field 21);

17. Date of service (HCFA Form 1500, field 24A);

18. Place of service codes for all claims, as designated by the Health Care Financing Administration for Medicare (HCFA Form 1500, field 24B);

19. Procedure code (HCFA Form 1500, field 24D);

20. Diagnosis code by specific service (HCFA Form 1500, field 24E);

21. Charge for each listed service (HCFA Form 1500, field 24F);

22. Number of days, time, in minutes, and start to stop time or units (HCFA Form 1500, field 24G);

23. The carrier-assigned provider number until the National Provider Identifier is developed and assigned, if applicable (HCFA Form 1500, field 24K);

24. Federal tax ID number of the health care practitioner or other person entitled to reimbursement (HCFA Form 1500, field 25);

25. Patient's account number (HCFA Form 1500, field 26);

26. Total charge (HCFA Form 1500, field 28);

27. For claims submitted electronically, a computer-printed name as the signature of the health care practitioner or other person entitled to reimbursement (HCFA Form 1500, field 31);

28. For claims not submitted electronically, the signature of the health care practitioner who provided the service or the other person entitled to reimbursement who provided the service, or a notation that the signature is on file with the health maintenance organization or preferred provider (HCFA Form 1500, field 31);

29. Name and address of the facility where the services were rendered, if other than a home or an office (HCFA Form 1500, field 32);

30. The billing name, address, zip code, phone number and, if applicable, carrier-assigned provider number until the National Provider Identifier (NPI) is developed and assigned to the health care practitioner or other person entitled to reimbursement (HCFA Form 1500, field 33); and

31. Any other field or essential data necessary to comply with the applicable standard code set.

686A.294 Claim by health care practitioner or other person entitled to reimbursement: Additional data required under certain circumstances. (NRS 679B.130, 679B.138, 686A.015) In addition to the data required by NAC 686A.292, a claim submitted by a health care practitioner or other person entitled to reimbursement must include the following data if circumstances exist that render the data applicable to the specific claim being filed:

1. If the patient is covered by more than one contract for health insurance, the following information that is applicable to the other insured or enrollee:

(a) Name (HCFA Form 1500, field 9);

(b) Policy or group number (HCFA Form 1500, field 9a);

(c) Date of birth (HCFA Form 1500, field 9b);

(d) Plan name, such as employer, school or other organization (HCFA Form 1500, field 9c); and

(e) Name of the health maintenance organization or insurer (HCFA Form 1500, field 9d);

2. Except in the case of a laboratory that was issued a license pursuant to chapter 652 of NRS, if the contract for health insurance is a group plan, the subscriber's plan name, including, without limitation, the employer, school or other organization (HCFA Form 1500, field 11b);

3. When prior authorization is required, the prior authorization number (HCFA Form 1500, field 23);

4. If the claim is between parties to a global contract, the code pursuant to the global contract (HCFA Form 1500, field 24D);

5. If the claim is for services rendered pursuant to the Medicaid Program, the code established by the Medicaid Program (HCFA Form 1500, field 24D);

6. When a modifier code is used to explain unusual circumstances, the modifier code (HCFA Form 1500, field 24D);

7. When an assignment has been proposed, whether the assignment was accepted (HCFA Form 1500, field 27); and

8. If an amount has been paid to the health care practitioner or other person entitled to reimbursement submitting the claim, by the patient or subscriber, or on behalf of the patient or subscriber:

(a) The amount paid (HCFA Form 1500, field 29); and

(b) The balance due (HCFA Form 1500, field 30).

686A.296 Claim by health care practitioner or other person entitled to reimbursement: Prohibited use of field; optional inclusion of additional data. (NRS 679B.130, 679B.138, 686A.015)

1. A payer shall not use or require a health care practitioner or other person entitled to reimbursement to use any field for purposes that are inconsistent with the essential data required pursuant to NAC 686A.292 and 686A.294, or in addition to the applicable standard code set.

2. A health care practitioner or other person entitled to reimbursement may elect to include data in addition to the data required pursuant to NAC 686A.292 and 686A.294.

686A.298 Claim by hospital or other institutional provider: Required form and data. (NRS 679B.130, 679B.138, 686A.015) A claim form submitted by a hospital or other institutional provider must be submitted on Health Care Financing Administration (HCFA) Form 1450 and must include the following data:

1. Name, address and telephone number of the hospital or other institutional provider (HCFA Form 1450, field 1);

2. Patient's control number (HCFA Form 1450, field 3);

3. Type of bill code (HCFA Form 1450, field 4);

4. Federal tax ID number of the hospital or other institutional provider (HCFA Form 1450, field 5);

5. Beginning and ending date of claim period (HCFA Form 1450, field 6);

6. Patient's name (HCFA Form 1450, field 12);

7. Patient's address (HCFA Form 1450, field 13);

8. Patient's date of birth (HCFA Form 1450, field 14);

9. Patient's gender (HCFA Form 1450, field 15);

10. Patient's marital status (HCFA Form 1450, field 16);

11. Date of admission (HCFA Form 1450, field 17);

12. Admission hour (HCFA Form 1450, field 18);

13. Type of admission, including, without limitation, emergent, urgent, elective or newborn (HCFA Form 1450, field 19);

14. Source of admission code (HCFA Form 1450, field 20);

15. Patient-status-at-discharge code (HCFA Form 1450, field 22);

16. Medical record number (HCFA Form 1450, field 23);

17. Responsible party's name and address (HCFA Form 1450, field 38);

18. Value codes and amounts (HCFA Form 1450, fields 39-41);

19. Applicable revenue code (HCFA Form 1450, field 42);

20. Revenue description (HCFA Form 1450, field 43);

21. Service date (HCFA Form 1450, field 45);

22. Units of service (HCFA Form 1450, field 46);

23. Total charges (HCFA Form 1450, field 47);

24. Noncovered charges (HCFA Form 1450, field 48);

25. Name of the payer (HCFA Form 1450, field 50);

26. Provider number (HCFA Form 1450, field 51);

27. Release of information (HCFA Form 1450, field 52);

28. Assignment of benefits (HCFA Form 1450, field 53);

29. Estimated amount due (HCFA Form 1450, field 55);

30. Subscriber's name (HCFA Form 1450, field 58);

31. Patient's relationship to the subscriber (HCFA Form 1450, field 59);

32. Patient's or subscriber's certificate number, health claim number and ID number (HCFA Form 1450, field 60);

33. Treatment authorization code (HCFA Form 1450, field 63);

34. Principal diagnosis code (HCFA Form 1450, field 67);

35. Admitting diagnosis (HCFA Form 1450, field 76);

36. Attending physician's ID (HCFA Form 1450, field 82);

37. Other physician's ID (HCFA Form 1450, field 83);

38. Signature of the provider representative or notation that the signature is on file with the payer (HCFA Form 1450, field 85);

39. Date the bill was submitted (HCFA Form 1450, field 86); and

40. Any other field or essential data necessary to comply with the applicable standard code set.

686A.300 Claim by hospital or other institutional provider: Additional data required under certain circumstances. (NRS 679B.130, 679B.138, 686A.015) In addition to the data

required pursuant to NAC 686A.298, a claim submitted to a payer by a hospital or other institutional provider must include the following data if circumstances exist that render the data applicable to the specific claim being filed:

1. If Medicare is a primary or secondary payer:

(a) The covered days (HCFA Form 1450, field 7);

(b) The noncovered days (HCFA Form 1450, field 8); and

(c) The coinsurance days (HCFA Form 1450, field 9);

2. If Medicare is a primary or secondary payer and the patient was an inpatient, the lifetime reserve days (HCFA Form 1450, field 10);

3. If the patient was an inpatient or was admitted for outpatient observation, the discharge hour (HCFA Form 1450, field 21);

4. If the HCFA Form 1450 manual contains condition codes appropriate to the patient's condition, the condition codes (HCFA Form 1450, fields 24-30);

5. If the HCFA Form 1450 manual contains occurrence codes appropriate to the patient's condition, the occurrence codes and dates (HCFA Form 1450, fields 32-35);

6. If the HCFA Form 1450 manual contains an occurrence span code appropriate to the patient's condition, the occurrence span code and date (HCFA Form 1450, field 36);

7. If there is a primary or secondary payer, the HFCA Common Procedure Coding System/Rates (HCFA Form 1450, field 44);

8. If the claim is between parties to a global contract, the code pursuant to the global contract (HCFA Form 1450, field 44);

9. If payments have been made to the hospital by the patient or another payer, the prior payments (HCFA Form 1450, field 54);

10. If there are payers of higher priority than the payer, including, without limitation, workers' compensation:

(a) The employment status code (HCFA Form 1450, field 64); and

(b) The employer name (HCFA Form 1450, field 65);

11. If there is workers' compensation involved, the employer location (HCFA Form 1450, field 66);

12. If there are diagnoses other than the principal diagnosis, the diagnoses codes other than the principal diagnosis code (HCFA Form 1450, fields 68-75);

13. For services provided in an emergency department of a hospital, the diagnoses codes describing the patient's signs or presenting symptoms (HCFA Form 1450, fields 68-75);

14. If the HCFA Form 1450 manual indicates a procedural coding method appropriate to the patient's condition, the procedural coding methods used (HCFA Form 1450, field 79);

15. If the patient has undergone an inpatient or outpatient surgical procedure, the principal procedure code (HCFA Form 1450, field 80); and

16. If additional surgical procedures were performed, and the HCFA Form 1450 manual indicates a procedural coding method, the procedure codes (HCFA Form 1450, field 81).

689A.431 Report concerning health insurance on franchise plan. (NRS 679B.130) On or before March 1 of each calendar year, an individual carrier that issues health insurance on a franchise plan pursuant to NRS 689A.370 shall file with the Commissioner a report concerning its operation during the preceding calendar year. The report must include, without limitation, the number of:

1. Policies of health insurance on a franchise plan that were in effect as of December 31 of the preceding calendar year; and

2. Employers who authorized policies of health insurance on a franchise plan during the preceding calendar year.