

## **Texas Administrative Code**

<u><a href="#">TITLE 28</a></u>	INSURANCE
<u><a href="#">PART 1</a></u>	TEXAS DEPARTMENT OF INSURANCE
<u><a href="#">CHAPTER 21</a></u>	TRADE PRACTICES
<u><a href="#">SUBCHAPTER T</a></u>	SUBMISSION OF CLEAN CLAIMS
<b>RULE §21.2803</b>	<b>Elements of a Clean Claim</b>

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(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) for non-electronic claims, the required data elements specified in subsection (b) of this section, or for non-electronic dental claims filed with an HMO, the required data elements specified in subsection (c) of this section;

(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 subsection; and

(3) if applicable, any coordination of benefits or non-duplication of benefits information pursuant to subsection (d) of this section.

(b) Required data elements. CMS 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 in paragraphs (1) and (2) of this subsection are based upon the terms used by CMS on successor forms CMS-1500 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.

(1) Required data elements for physicians or noninstitutional providers. 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.

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

(B) patient's name (CMS 1500, field 2) is required;

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

(D) subscriber's name (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) (CMS 1500, field 5) is required;

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

(G) subscriber's address (street or P.O. Box, city, state, zip) (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, field 9), is required if 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 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, field 9a), is required if 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 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, field 9b), is required if 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 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, field 9c), is required if 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 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 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, field 9d), is required if 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 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, 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, field 10d);

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

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

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

(i) if respond "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 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 (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 respond "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, 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, 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, field 13) is required;

(T) date of injury (HCFA 1500, field 14) is required, if due to an accident;

(U) 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) 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, 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, 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, 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, field 23), is required when prior authorization is required and granted;

(Z) date(s) of service (CMS 1500, field 24A) is required;

(AA) place of service codes (CMS 1500, field 24B) is required;

(BB) procedure/modifier code (CMS 1500, field 24D) is required;

(CC) diagnosis code by specific service (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, field 24F) is required;

(EE) number of days or units (CMS 1500, field 24G) is required;

(FF) physician's or provider's federal tax ID number (CMS 1500, field 25) is required;  
(GG) whether assignment was accepted (CMS 1500, field 27), is required if assignment under Medicare has been accepted;

(HH) total charge (CMS 1500, field 28) is required;

(II) amount paid (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 (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, field 31) is required;

(KK) name and address of facility where services rendered (if other than home or office) (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, 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.

(2) Required data elements for institutional providers. 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.

(A) provider's name, address and telephone number (UB-92, field 1) is required;

(B) patient control number (UB-92, field 3) is required;

(C) type of bill code (UB-92, field 4) is required and shall include a "7" in the third position if the claim is a corrected claim;

(D) provider's federal tax ID number (UB-92, field 5) is required;

(E) statement period (beginning and ending date of claim period) (UB-92, field 6) is required;

(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) patient's name (UB-92, field 12) is required;

(K) patient's address (UB-92, field 13) is required;

(L) patient's date of birth (UB-92, field 14) is required;

(M) patient's gender (UB-92, field 15) is required;

(N) patient's marital status (UB-92, field 16) is required;

(O) date of admission (UB-92, field 17) is required for admissions, observation stays, and emergency room care;

(P) admission hour (UB-92, field 18) is required for admissions, observation stays, and emergency room care;

(Q) type of admission (e.g., emergency, urgent, elective, newborn) (UB-92, field 19) is required for admissions;

- (R) source of admission code (UB-92, field 20) is required;
- (S) discharge hour (UB-92, field 21), is required for admissions, outpatient surgeries or observation stays;
- (T) patient-status-at-discharge code (UB-92, field 22) is required for admissions, observation stays, and emergency room care;
- (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) occurrence span code, from and through dates (UB-92, field 36), are required if the CMS UB-92 manual contains an occurrence span code appropriate to the patient's condition;
- (X) value code and amounts (UB-92, 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;
- (Y) revenue code (UB-92, field 42) is required;
- (Z) revenue description (UB-92, field 43) is required;
- (AA) HCPCS/Rates (UB-92, field 44), are required if Medicare is a primary or secondary payor;
- (BB) Service date (UB-92, field 45) is required if the claim is for outpatient services;
- (CC) units of service (UB-92, field 46) are required;
- (DD) total charge (UB-92, field 47) is required;
- (EE) HMO or preferred provider carrier name (UB-92, field 50) is required;
- (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) patient's relationship to subscriber (UB-92, field 59) is required;

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

(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) admitting diagnosis code (UB-92, field 76) is required;

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

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

(UU) date bill submitted (UB-92, field 86) is required.

(c) Required data elements-dental claims. The data elements described in this subsection are required as indicated and must be completed or provided in accordance with the special instructions applicable to the data elements for non-electronic clean claims filed by dental providers with HMOs.

(1) Patient's name is required;

(2) Patient's address is required;

- (3) Patient's date of birth is required;
- (4) Patient's gender is required;
- (5) Patient's relationship to subscriber is required;
- (6) Subscriber's name is required;
- (7) Subscriber's address is required, but provider may enter "same" if the subscriber's address is the same as the patient's address required by paragraph (2) of this subsection;
- (8) Subscriber's date of birth is required, if shown on the patient's ID card;
- (9) Subscriber's gender is required;
- (10) Subscriber's identification number is required, if shown on the patient's ID card;
- (11) Subscriber's plan/group number is required, if shown on the patient's ID card;
- (12) HMO's name is required;
- (13) HMO's address is required;
- (14) Disclosure of any other plan providing dental benefits is required and shall include a "no" if the patient is not covered by another plan providing dental benefits. If the patient does have other coverage, the provider shall indicate "yes" and the elements in paragraphs (15) - (20) of this subsection are required unless the provider submits with the claim documented proof to the HMO that the provider has made a good faith but unsuccessful attempt to obtain from the enrollee any of the information needed to complete the data elements;
- (15) Other insured's or enrollee's name is required in accordance with the response to and requirements of paragraph (14) of this subsection;
- (16) Other insured's or enrollee's date of birth is required in accordance with the response to and requirements of the element in paragraph (15) of this subsection;
- (17) Other insured's or enrollee's gender is required in accordance with the response to and requirements of the element in paragraph (15) of this subsection;
- (18) Other insured's or enrollee's identification number is required in accordance with the response to and requirements of the element in paragraph (15) of this subsection;
- (19) Patient's relationship to other insured or enrollee is required in accordance with the response to and requirements of the element in paragraph (15) of this subsection;

(20) Name of other HMO or insurer is required in accordance with the response to and requirements of the element in paragraph (15) of this subsection;

(21) Verification or preauthorization number is required, if a verification or preauthorization number was issued by an HMO to the provider;

(22) Date(s) of service(s) or procedure(s) is required;

(23) Area of oral cavity is required, if applicable;

(24) Tooth system is required, if applicable;

(25) Tooth number(s) or letter(s) are required, if applicable;

(26) Tooth surface is required, if applicable;

(27) Procedure code for each service is required;

(28) Description of procedure for each service is required, if applicable;

(29) Charge for each listed service is required;

(30) Total charge for the claim is required;

(31) Missing teeth information is required, if a prosthesis constitutes part of the claim. A provider that provides information for this element shall include the tooth number(s) or letter(s) of the missing teeth;

(32) Notification of whether the services were for orthodontic treatment is required. If the services were for orthodontic treatment, the elements in paragraphs (34) and (35) of this subsection are required;

(33) Date of orthodontic appliance placement is required, if applicable;

(34) Months of orthodontic treatment remaining is required, if applicable;

(35) Notification of placement of prosthesis is required, if applicable. If the services included placement of a prosthesis, the element in paragraph (36) of this subsection is required;

(36) Date of prior prosthesis placement is required, if applicable;

(37) Name of billing provider is required;

(38) Address of billing provider is required;



(39) Billing provider's provider identification number is required, if applicable;

(40) Billing provider's license number is required;

(41) Billing provider's social security number or federal tax identification number is required;

(42) Billing provider's telephone number is required; and

(43) Treating provider's name and license number are required if the treating provider is not the billing provider.

(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, field 29 or UB-92, field 54 must be completed pursuant to subsection (b)(1)(II) and (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, field 29 or UB-92, field 54 must be completed pursuant to subsection (b)(1)(II) and (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, field 29 or UB-92, field 54 must be completed pursuant to subsection (b)(1)(II) and (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) A physician or provider submits an electronic clean claim by submitting a claim using the applicable format that complies with all applicable federal laws related to electronic health care claims, including applicable implementation guides, companion guides and trading partner agreements.

(f) If a physician or provider submits an electronic clean claim that requires coordination of benefits pursuant to §§3.3501-3.3511 of this title (relating to Group Coordination of Benefits) or §11.511(1) of this title (relating to Optional Provisions), the HMO or preferred provider carrier processing the claim as a secondary payor shall rely on the primary payor information submitted on the claim by the physician or provider. The primary payor may submit primary payor information electronically to the secondary payor using the ASC X12N 837 format and in compliance with federal laws related to

electronic health care claims, including applicable implementation guides, companion guides and trading partner agreements.

(g) Format of elements. The elements of a clean claim set forth in subsections (b), (c), (d), (e) and (f), if applicable, of this section must be complete, legible and accurate.

(h) Additional data elements or information. The submission of data elements or information on or with a claim form by a physician or provider in addition to those required for a clean claim under this section shall not render such claim deficient.