TO BE RESCINDED

3901-1-59 **Standardized health claim form rule.**

(A) Authority

Section 3901.041 of the Revised Code provides that the superintendent shall adopt, amend, and rescind rules and make adjudications necessary to discharge his duties and exercise his powers under Title XXXIX of the Revised Code. This rule is promulgated under authority of section 3902.22 of the Revised Code to provide for a standard claim form to be used by all third-party payers for reimbursement of health care services and supplies. Sections 3901.20 and 3901.21 of the Revised Code respectively prohibit unfair or deceptive practices in the business of insurance and define certain acts or practices as unfair or deceptive. Section 3901.21 of the Revised Code also provides that the enumeration of specific unfair or deceptive acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the power of the superintendent to adopt rules to implement that section.

(B) Purpose

The purpose of this rule 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 electronic data interchange of health care expenses and reimbursement.

(C) Definitions

As used in this rule

(1) "CDT codes" means the most current dental terminology and codes prescribed by the American dental association.

(2) "Claim" means any request submitted to a third-party payer for benefits or proceeds under a benefit plan or contract on a standardized health claim form as described in paragraph (E)(2) of this rule.

(3) "CPT codes" means the most current procedural terminology and codes as published by the American medical association.

(4) "CMS" means the centers for medicare and medicaid services of the U.S. department of health and human services formerly known as the federal health care financing administration of the U.S. department of health and human services (HCFA).

(5) "CMS Form 1450" means the health insurance claim form published by CMS for use by institutional care practitioners. For purposes of this rule, the CMS form 1450 includes the UB-82 or UB-92 forms and their successors.

(6) "CMS Form 1500" means the health insurance claim form published by CMS for use by health care practitioners. For purposes of this rule, the CMS Form 1500 will include successor forms as approved by CMS.

(7) "HCPCS" means CMS's common procedure coding system which is based upon the AMA's most current CPT publication.

(a) "HCPCS Level 1 codes" means the AMA's CPT codes with the exception of anesthesiology services;

(b) "HCPCS Level 2 codes" means the codes for physician and non-physician services which are not included in the most current CPT publication;

(c) "HCPCS Level 3 codes" means the codes for services needed by individual contractors or state agencies to process claims. They are used for items and services not having the frequency of use, geographic distribution, or general applicability needed to justify a code assignment at a higher level.

(8) "Health care practitioner" means:

(a) A chiropractor licensed under Chapter 4734. of the Revised Code;

(b) A corporation or partnership of health care practitioners defined in this section;

(c) A dentist licensed under Chapter 4715. of the Revised Code;

(d) A dietitian licensed under Chapter 4759. of the Revised Code;

(e) A nurse licensed under Chapter 4723. of the Revised Code;

(f) An optometrist licensed under Chapter 4725. of the Revised Code;

(g) A physician as defined under section 4730.01 of the Revised Code;

(h) A podiatrist licensed under Chapter 4731. of the Revised Code;

(i) A psychologist licensed under Chapter 4732. of the Revised Code;

(j) A therapist, including speech, physical, respiratory and occupational therapists licensed under Chapter 4753., 4755. or 4761. of the Revised Code.

(9) "ICD-9-CM codes" means the disease codes in the most current international classification of diseases, clinical modifications published by the U.S. department of health and human services.

(10) "Institutional care practitioner" means:

(a) A hospice licensed under Chapter 3712. of the Revised Code;

(b) A hospital as defined under section 3727.01 of the Revised Code;

(c) A skilled nursing facility, extended care facility, intermediate care facility, convalescent nursing home, or adult care facility licensed under Chapters 3721. and 3722. of the Revised Code.

(11) "J515 form" means the uniform dental claim form approved by the American dental association for use by dentists. For purposes of this rule, the J515 form shall include its successors.

(12) "Medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

(13) "NCPDP universal claim form" means the form adopted for use by the national council for prescription drug programs, including numbers DAH 3-97 and DAH 2PT and its successors.

(14) "Other provider" means a supplier of health care services or supplies not meeting the definition of health care practitioner or institutional care practitioner, including but not limited to a pharmacist, physician assistant, nurse aide, or supplier of durable medical equipment.

(15) "Third-party payer" is as defined in R.C. 3901.38.

(D) Applicability and scope

Except as otherwise specifically provided, the requirements of this rule apply to all issuers of policies or contracts of insurance, administrators of self-funded employee benefit plans, and other forms of coverage involved in the reimbursement of health care expenses, and all health care and institutional care practitioners licensed by this state. It is not to cover claims involving medicare, parts A or B; medicaid, the tricare program or workers' compensation insurance. Nothing herein shall be construed to create or imply a private cause of action for violation of this rule.

(E) General provisions

(1) A health care practitioner, institutional care practitioner, or other provider shall file a claim on the CMS 1500, UB-82/UB-92/CMS-1450, NCPDP universal claim form or the J515 claim forms (and their successor forms) which, for the purpose of this rule, are deemed approved for use in this state.

(2) Third-party payers transacting business in this state shall accept claims submitted on the CMS 1500, UB-82/UB-92/CMS-1450, NCPDP universal claim form or the J515 claim forms (and their successor forms) which, for the purpose of this rule, are deemed approved for use in this state.

(3) Nothing in this regulation shall prohibit a third-party payer and an institutional care practitioner, health care practitioner or other provider from entering into a mutual agreement regarding the submission of claims to the third-party payer.

(4) All health care practitioners and institutional care practitioners shall:

(a) Use the most current editions of the CMS form 1500, CMS Form 1450 or J515 and most current instructions for these forms in filing claims with third-party payers.

(b) Modify their billing 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 rule;

(5) Nothing in this regulation shall prevent a third-party payer from requesting supporting documentation as described in section 3901.381 of the Revised Code.

(F) Requirements for use of CMS form 1500

(1) Health care practitioners, other than dentists, shall use the CMS form 1500 and instructions provided by CMS for use of the CMS form 1500 when filing claims with third-party payers for professional services.

(2) A third-party payer may not require a health care practitioner to use any coding system for the filing of claims for health care services other than the following:

(a) HCPCS Codes (and their successors);

(b) ICD-9-CM Codes (and their successors);

(c) CPT Codes (and their successors).

(3) For anesthesia services use HCPCS level 1 codes for anesthesia.

(4) Third party payers may accept the American society of anesthesiologists relative value guide codes for anesthesia services if mutually agreed to with the provider.

(5) A third-party payer may not require a health care practitioner to use any other descriptor with a code or to furnish additional information with the initial submission of a CMS form 1500 except under the following circumstances:

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

(b) When the procedure code is followed by the CPT modifier 22, 52 or 99. A health care practitioner may use item 19 of the CMS form 1500 to explain the multiple modifiers.

(6) A health care practitioner may use box 19 of the CMS form 1500 to indicate the form is an amended version of a form previously submitted to the third-party payer by inserting the word "amended" in the space provided.

(7) A health care practitioner billing for services based on the amount of time involved shall indicate the number of units in item 24 g of the CMS form 1500 if it is not used to specify the number of days of treatment.

(8) Third-party payers shall provide reimbursement to health care practitioners and other providers using the first that applies:

(a) Medicare physician identification number (UPIN);

(b) Federal tax identification number;

(c) Social security number.

(G) Requirements for use of CMS form 1450/UB82/UB92

(1) Institutional care practitioners shall use the CMS form 1450 and instructions provided by CMS for use of the CMS form 1450 when filing claims with third-party payers for professional services.

(2) A third-party payer may not require an institutional care practitioner to use any coding system for the filing of claims for health care services other than the following:

(a) ICD-9-CM codes (and their successors);

(b) HCPCS level 1 codes (and their successors);

(c) HCPCS level 2 codes (and their successors);

(d) HCPCS level 3 codes (and their successors); and

(e) Other codes as accepted by the national uniform billing committee;

(f) If charges include direct service of a health care practitioner, the information outlined in paragraph (E) of this rule.

(3) Institutional care practitioners shall specify the license number of physical therapists and other health care professionals rendering services designated as physical therapy in block 83 of CMS form 1450.

(H) Requirements for use of J515 form:

(1) A dentist shall use the J515 form and instructions provided by the American

dental association for billing patients or their representatives directly and filing claims with third-party payers for professional services;

(2) A third-party payer may not require a dentist to use any code other than the CDT codes, or their successors, for the filing of claims for dental care services.

(I) Requirements for use of NCPDP universal claim form

A pharmacist shall use the NCPDP universal claim form, or its successors, to submit claims with third party payers.

(J) Penalties

Failure to comply with any requirements of paragraphs (E) to (I) of this rule is an unfair and deceptive practice within the meaning of section 3901.21 of the Revised Code.

(K) Severability

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

Effective: 07/01/2012

R.C. 119.032 review dates: 08/26/2011

CERTIFIED ELECTRONICALLY

Certification

01/03/2012

Date

Promulgated Under: 119.03
Statutory Authority: 3901.041, 3901.21, 3902.22
Rule Amplifies: 3901.21, 3901.38 to 3901.3813, 3902.22, 3902.23
Prior Effective Dates: 1/8/1994, 1/1/1996, 10/28/2002, 4/5/2007