This rule was filed as 13 NMAC 10.12.

TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 12 STANDARDIZED HEALTH CLAIM FORMS

13.10.12.1 ISSUING AGENCY: New Mexico State Corporation Commission [Public Regulation Commission], Department of Insurance, Post Office Box 1269, Santa Fe, NM 87504-1269.
[7/1/97; Recompiled 11/30/01]

13.10.12.2 SCOPE:

A. Except as otherwise specifically provided, the requirements of this rule apply to issuers as defined herein.

B. Nothing in this rule shall prevent an issuer from requesting additional information that is not contained on the forms required under this rule 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 rule shall prohibit an issuer from accepting 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; however, such a contract does not relieve a health care practitioner, institutional care practitioner or issuer from data reporting requirements under federal law or other state law.

D. Nothing in this rule shall prohibit electronic claims submission if agreed upon by the issuer and health care practitioner or institutional care practitioner.
[7/1/94; Recompiled 11/30/01]

13.10.12.3 STATUTORY AUTHORITY: Sections 59A-2-9 and 59A-18-27.1 NMSA 1978.
[7/1/94; Recompiled 11/30/01]

13.10.12.4 DURATION: Permanent.
[7/1/97; Recompiled 11/30/01]

13.10.12.5 EFFECTIVE DATE: July 1, 1994, unless a later date is cited at the end of a section or paragraph. Repromulgated in NMAC format effective July 1, 1997.
[7/1/94, 7/1/97; Recompiled 11/30/01]
[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

13.10.12.6 OBJECTIVE: The purpose and intent of this rule is to implement the provisions of Section 59A-18-27.1 NMSA 1978, to standardize the forms used in the billing and reimbursement of health care expenses, to reduce the number of forms utilized, to increase efficiency in the reimbursement of health care through standardization and to encourage the use of and prescribe a timetable for implementation of electronic interchange of health care expense and reimbursement data.
[7/1/94; Recompiled 11/30/01]

13.10.12.7 DEFINITIONS:

A. **"CDT - 1"** codes means the current dental terminology prescribed by the American dental association.

B. **"CPT - 4"** codes means the current procedural terminology published by the American medical association.

C. **"HCFA"** means the health care financing administration of the U.S. department of health and human services.

D. **"HCFA form 1450"** means the health insurance claim form published by HCFA for use by institutional care practitioners, or any successor form published by HCFA to replace form 1450.

E. **"HCFA form 1500"** means the health insurance claim form published by HCFA for use by health care practitioners, or any successor form published by HCFA to replace form 1500.

F. **"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 alphanumeric 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 alphanumeric codes and modifiers for items and services not included in HCPCS level 1 or HCPCS level 2.

G. **"Health care practitioner"** means:

(1) an acupuncturist licensed under Chapter 61, Article 14A NMSA 1978;

(2) a chiropractor licensed under, Chapter 61, Article 4 NMSA 1978;

(3) a corporation or partnership of health care practitioners defined in this section;

(4) a dentist licensed under Chapter 61, Article 5 NMSA 1978;

(5) a nurse licensed under Chapter 61, Article 3 NMSA 1978 ;

(6) an ophthalmologist otherwise defined as a health care practitioner in this section;

(7) an optometrist licensed under Chapter 61, Article 2 NMSA 1978;

(8) a physician licensed under Chapter 61, Article 6 NMSA 1978;

(9) a podiatrist licensed under Chapter 61, Article 8 NMSA 1978;

(10) a psychologist licensed under Chapter 61, Article 9 NMSA 1978;

(11) a speech, physical, respiratory or occupational therapist licensed under Chapter 61, Articles 12, 12A, 12B, or 14B NMSA 1978;

(12) a counselor or therapist licensed under Chapter 61, Article 9A NMSA 1978;

(13) an osteopath licensed under Chapter 61, Article 10 NMSA 1978; and

(14) a home health care provider.

H. **"ICD - 9 - CM codes"** means the disease codes in the *International Classification of Diseases, Ninth Revision*, clinical modifications published by the U.S. department of health and human services.

I. **"Institutional care practitioner"** means a health facility as defined under Chapter 24, Article 1 NMSA 1978.

J. **"Issuer"** means an insurer, fraternal benefit society, non profit health care plan, health maintenance organization, prepaid plan, third party administrator, and any other entity reimbursing the costs of health care expenses, other than a governmental agency.

K. **"J512 form"** means the uniform dental claim form approved by the American dental association for use by dentists.

L. **"Medicare"** means the health insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

M. **"Medical assistance or medicaid"** means Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) as then constituted or later amended; and

N. **"Revenue codes"** means the codes established for use by institutional care practitioners by the national uniform billing committee.

[7/1/94, 7/1/97; Recompiled 11/30/01]

13.10.12.8 REQUIREMENTS FOR USE OF HCFA FORM 1500:

A. Issuers shall accept from health care practitioners other than dentists the HCFA form 1500 for claims for professional services.

B. Issuers may not require health care practitioners to use any coding system for the initial filing of claims for health care services other than the following:

(1) HCPCS codes; and

(2) ICD - 9 - CM codes.

C. Issuers may not require health care practitioners to use any other descriptor with a code or to furnish additional information with the initial submission of a HCFA form 1500 except 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 utilizing HCFA form 1500 shall:

(1) follow HCFA's instructions for use of the form;

(2) when amending a form previously submitted to the issuer, insert the word "amended" in the space provided in Box 19 of the form;

(3) if billing patients directly, provide a properly completed HCFA form 1500 in addition to any other explanatory information used to bill the patient when requested by the patient;

(4) if billing for services based on the amount of time involved, define on line 19 the time interval in item 24 G of the HCFA form 1500. If not defined, units will be assumed to be days of treatment; and

(5) provide the unique physician identification number assigned by HCFA in box 17a, and the federal tax identification number or social security number in Item 25.

[7/1/94, 7/1/97; Recompiled 11/30/01]

13.10.12.9 REQUIREMENTS FOR USE OF HCFA FORM 1450:

A. Issuers shall accept from institutional care practitioners the HCFA form 1450 for claims for health care services.

B. Issuers may not require institutional care practitioners to use any coding system for the initial filing of claims for health care services other than the following:

(1) ICD - 9 - CM codes;

(2) revenue codes;

(3) HCPCS codes; and

(4) if charges include direct service furnished by a health care practitioner, the information outlined in Section 5 of this rule.

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.

D. Institutional care providers that utilize HCFA form 1450 for submission of claims to issuers and 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.

[7/1/94, 7/1/97; Recompiled 11/30/01]

13.10.12.10 REQUIREMENTS FOR USE OF J512 FORM:

A. Issuers shall accept the J512 form for claims for professional dental services.

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.

C. Dentists utilizing the J512 form for submission of claims for professional dental services shall:

(1) follow the instructions for the form provided by the American dental association CDT - 1; and

(2) if billing patients directly, provide a properly completed J512 form in addition to any other form used to bill the patient when requested by the patient.

[7/1/94; Recompiled 11/30/01]

13.10.12.11 GENERAL PROVISIONS:

A. Issuers shall:

(1) accept the most current editions of the HCFA form 1500, HCFA form 1450, or J512 form completed in accordance with the most current instructions for these forms from health care practitioners and institutional care practitioners; and

(2) modify their 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 rule.

B. Health care practitioners and institutional care practitioners utilizing HCFA form 1500, HCFA form 1450, or the J512 form shall use the most current version of the forms and applicable instructions. Claims filed in paper form shall be printed on 8.5 x 11 inch paper.

C. Issuers may require that claims be submitted on HCFA form 1500, HCFA form 1450, or the J512 form.

[7/1/94; Recompiled 11/30/01]

HISTORY OF 13.10.12 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center as:

SCC 93-8-IN, Standardized Health Claim Forms, filed 12/1/93.

History of Repealed Material: [RESERVED]