

**INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
REGULATION NO. 178
11 NYCRR 217
PROMPT PAYMENT OF HEALTH INSURANCE CLAIMS**

I, Louis Pietroluongo, First Deputy Superintendent & COO of the Insurance Department of the State of New York, pursuant to the authority granted by Sections 201, 301, 1109, 2403, 3224, and 3224-a of the Insurance Law of the State of New York, hereby promulgate a new Part 217 of Chapter IX of Title 11 of the Official Compilation of Codes, Rules and Regulations of the State of New York (Regulation No. 178), to take effect upon publication in the State Register, to read as follows:

(ALL MATERIAL IS NEW)

Section 217.1 Definitions and applicability.

(a) For the purposes of this Part:

(1) "Payer" shall mean an insurer authorized to write accident and health insurance or that is licensed pursuant to Article 43 of the New York Insurance Law, or an entity certified pursuant to Article 44 of the Public Health Law.

(2) "Submitted on paper" shall include claims submitted on paper or by facsimile.

(b) This Part shall apply to all health care claims submitted under contracts or agreements issued or entered into pursuant to Articles 32, 42 or 43 of the Insurance Law or Article 44 of the Public Health Law.

Section 217.2 Health Insurance claim submission guidelines.

(a) A claim for payment of medical or hospital services submitted on paper shall be deemed complete if it contains the minimum data elements set forth in this Part. If the minimum data elements set forth are not present or accurate, the payer may, but need not, adjudicate the claim if the payer can determine, based on the information submitted, whether such claim should be paid or denied. Even if the claim is deemed complete, a payer may, pursuant to the provision of Section 3224-a(b) of the New York Insurance Law, request specific additional information, distinct from information on the claim form, necessary to make a determination as to its obligation to pay such claim.

(b)(1) In the case of a medical claim submitted on the national standard form known as a CMS 1500 (previously known as HCFA 1500 (New York State)), attached as an appendix (Appendix 26), the claim shall contain at least the items in the following fields of the claim form, except as provided in paragraph (2) of this subdivision:

- 1a. Insured's I.D. Number
2. Patient's Name
3. Patient's Date of Birth and Gender
4. Insured's Name (Last Name, First Name)
5. Patient's Address
9. Other Insured's Name (if appropriate)
- 9a. Other Insured's Policy or Group Number (if appropriate)
- 9b. Other Insured's Date of Birth and Gender (if appropriate)
- 9c. Employer's Name or School Name (if appropriate)
- 9d. Insurance Plan Name or Program Name (if appropriate)
- 10a. Is Patient's Condition Related to Employment?
- 10b. Is Patient's Condition Related to Auto Accident?
- 10c. Is Patient's Condition Related to Other Accident?
11. Insured's Policy, Group or FECA Number (if provided on ID Card)
- 11d. Is There Another Health Benefit Plan?
12. Patient's or Authorized Person's Signature (Can be completed by writing "signature on file" where appropriate)
13. Insured's or Authorized Person's Signature (if appropriate)
17. Name of Referring Physician or Other Source (if appropriate)
- 17a. I.D. Number of Referring Physician (if appropriate)
18. Hospitalization Dates Related to Current Services (if appropriate)
21. Diagnosis or Nature of Illness or Injury
- 24A. Dates of Service
- 24B. Place of Service
- 24D. Procedures, Services, or Supplies
- 24E. Diagnosis Code (refer to item 21)
- 24F. \$ Charges
- 24G. Days or Units (for Durable Medical Equipment) (if appropriate)
25. Federal Tax I.D. Number
28. Total Charge
29. Amount Paid (if appropriate)
30. Balance Due
31. Signature of Physician or Supplier Including Degrees or Credentials (if not already on file, except as required by applicable Federal and State laws)
33. Personal Identifying Number of the particular practitioner rendering the care plus, if practicing in a group, the Identifying Number of the group as well

(2) For items listed in paragraph (1) of this subdivision with the notation "(if appropriate)", the generic nature of the standard claim form produces some instances when the information is not

relevant in a particular instance. In those cases, the payer shall not insist upon completion of that item if the information is not relevant to the situation of that particular practitioner or patient or the information will not be used by the payer. If an item is not applicable at all, it should be left blank rather than inserting a notation that it is not applicable.

(c)(1) In the case of a hospital claim submitted on the national standard form HCFA 1450 (also known as UB-92), attached as an appendix (Appendix 27), the claim shall contain at least the items in the following fields of the claim form, except as provided in paragraph (2) of this subdivision:

1. Provider Name and Address
3. Patient Control Number
4. Type of Bill
5. Federal Tax Number
6. Statement Covers Period
7. Covered Days (if appropriate) (interim bill, etc)
8. Non-Covered Days (if appropriate)
9. Coinsurance Days (if appropriate)
10. Lifetime Reserve Days (if appropriate)
11. Newborn Birthweight (if appropriate)
12. Patient Name
13. Patient Address
14. Patient Birthdate
15. Patient Sex
17. Admission Date
18. Admission Hour
19. Type of Admission
22. Discharge Status Code
42. Revenue Codes
43. Revenue Description
44. HCPCS/CPT4 Codes
45. Service Date
46. Service Units
47. Total Charges (by revenue code)
48. Non-Covered Charges
50. Payer Name
51. Provider ID
54. Other Insurance Payment (if appropriate)
55. Estimated Amount Due (if appropriate)
58. Insured's Name
59. Patient Relationship
60. Patient's Cert. SSN - HIC - ID No.
62. Insurance Group Number (if on card) (where appropriate)
67. Principal Diagnosis Code
68. Code

69. Code
70. Code
71. Code
72. Code
73. Code
74. Code
75. Code
76. Admitting Diagnosis Code
77. E-Code
78. DRG #
79. P.C.
80. Principal Procedure Code and Date
81. Other Procedures Code and Date
82. Attending Physician's ID Number

(2) For items listed in paragraph (1) of this subdivision with the notation "(if appropriate)", the generic nature of the standard claim form produces some instances when the information is not relevant in a particular instance. In those cases, the payer shall not insist upon completion of that item if the information is not relevant to the situation of that particular practitioner or patient or the information will not be used by the payer. If an item is not applicable at all, it should be left blank rather than inserting a notation that it is not applicable.

(d) Nothing in this Part shall prohibit a payer from electing to accept some or all claims with less information than that specified in the lists set forth in subdivisions (b) and (c) of this section.

A new Appendix 26 of Title 11 is adopted to read as follows:

A new Appendix 27 of Title 11 is adopted to read as follows:

I, Louis Pietroluongo, First Deputy Superintendent & COO of the Insurance Department of the State of New York, do hereby certify that the foregoing is 11 NYCRR 217 (Regulation No. 178), promulgated by me on January 11, 2005 pursuant to the authority granted by Sections 201, 301, 1109, 2403, 3224, and 3224-a of the Insurance Law, to take effect upon publication in the State Register.

Pursuant to the provisions of the State Administrative Procedure Act, prior notice of the proposed amendment was published in the State Register on November 10, 2004. No other publication or prior notice is required by statute.

Louis Pietroluongo
First Deputy Superintendent & COO

Dated: January 11, 2005