11 NCAC 12 .1501 is readopted as published in NCR 34:10 839 as follows:

SECTION .1500 - UNIFORM CLAIM FORMS

11 NCAC 12 .1501 DEFINITIONS

In this Section, unless the context [~~clearly~~] indicates otherwise:

(1) "CPT-4 Codes" means the Physician Current Procedural [~~Terminology, Fourth Edition,~~] Terminology published by the American Medical Association.

(2) "Current ADA Dental Claim Form" means the most recent health insurance claim form published by the American Dental Association.

(3) "Ethnic origin code" is the established Ethnic (Race) Code as used by the Economics and Statistics Administration, Bureau of Labor Statistics, U.S. Department of Commerce.

(4) [~~"HCFA"~~] "CMS" [~~means the Health Care Financing Administration~~] means Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(5) [~~"HCFA Form 1450 (UB92)"~~] "CMS Form 1450 (UB-04)" means the health insurance claim form published by the [~~HCFA~~] CMS for use by institutional health care providers.

(6) [~~"HCFA Form 1500"~~] "CMS Form 1500" means the health insurance claim form published by the [~~HCFA~~] CMS for use by individual health care providers.

(7) "HCPCS" means [~~HCFA's~~] Healthcare Common Procedure Coding System, a coding system that describes products, supplies, procedures, and health care provider services; and includes the CPT-4 Codes, alphanumeric codes, and related modifiers. HCPCS includes:

(a) "HCPCS [~~Level 1~~] Level I Codes", which are the CPT-4 codes and modifiers for professional services and procedures;

(b) "HCPCS [~~Level 2~~] Level II Codes", which are national alphanumeric codes and modifiers for health care products and suppliers, as well as some codes for professional services not included in the CPT-4 Codes;

(c) "HCPCS [~~Level 3~~] Level III Codes", which are local alphanumeric codes and modifiers for items and services not included in HCPCS [~~Level 1~~] Level I or HCPCS [~~Level 2,~~] Level II.

(8) "ICD-9-CM Codes" means the diagnosis and procedure codes in the International Classification of Diseases, [~~Ninth Revision,~~] Clinical Modifications, published by the U.S. Department of Health and Human Services.

(9) "Individual health care provider" includes any individual, [~~natural person who,~~] who under Chapter 90 of the General Statutes is licensed, registered, or certified to engage in the practice of or performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, or psychology.

(10) "Institutional health care provider" includes:

(a) a hospital [~~licensed~~] defined under G.S. 131E-176(13);

(b) an ambulatory surgical facility [~~licensed~~] defined under [~~G.S. 131E-176(1a);~~] G.S. 131E-176(1b);

(c) a health service facility [~~licensed~~] defined under G.S. 131E-176(9b);

(d) a home health agency [~~licensed~~] defined under G.S. 131E-176(12);

(e) any of the entities listed in G.S. 58-55-35.

(11) "Payor" means an entity that provides a "health benefit plan", as defined in G.S. 58-3-171(c).

(12) "Standard claim form" means the [~~HCFA~~] CMS Form 1450 [~~(UB92),~~] (UB-04), [~~HCFA~~] CMS Form 1500, or the current ADA Dental Claim Form.

[~~(13) "SUBC" means the North Carolina State Uniform Billing Committee.~~]

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. ~~October 1, 1994.~~ October 1, 1994;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1502 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1502 REQUIREMENTS FOR USE OF [~~HCFA~~] CMS FORM 1450 [~~(UB92)~~] (UB-04)

(a) [~~Effective January 1, 1995, the~~] The [~~HCFA~~] CMS Form 1450 [~~(UB92)~~] (UB-04) shall be the standard claim form for all manual billing by institutional health care providers, and the [~~HCFA~~] CMS Form 1450 shall be accepted by all payors conducting business in this State.

~~[(b) Effective January 1, 1995, with implementation to be complete no later than April 1, 1995, the following additional information and placement location shall be required for the HCFA Form 1450 (UB92):~~

~~(1) The provider tax I.D. number shall be located in form locator 5.~~

~~(2) The ethnic origin code shall be located in form locator 24-30 (Condition Codes), using Code X1-X5 (see definitions as defined in the State Uniform Billing Manual) to translate the ethnic origin codes.]~~

~~[(c)~~](b) [~~Effective October 1, 1995, the~~] The cause of injury code shall be located in form locator [~~77.~~] 72. This code shall be required on all [~~HCFA~~] CMS Form 1450 [~~(UB92)~~] (UB-04) claims generated by institutional health care providers for claims of inpatients and of patients treated in emergency rooms or trauma centers; and where the diagnosis includes an injury diagnosis, which means a diagnostic code in the range or 800-999 as defined in the [~~ICD-9~~] ICD-10 coding manual. [~~Coding of the cause of injury shall be in accordance with the standards in the publication entitled, "Coding and Reporting of External Causes of Injury and Poisoning Recommended Coding Guidelines for ICD-9-CM", which standards are incorporated by reference into this Rule, including subsequent amendments and editions. Copies of the publication can be obtained from the Center for Health Policy Studies, 9700 Patuxent Woods Drive, Columbia, Maryland 21046-1577, for twenty-five dollars ($25.00) each. The absence of this code may not be used to deny the payment of a claim.]~~

~~[(d)~~] (c) Payors may require institutional health care providers to use only the following coding systems for the filing of claims for health care services:

(1) [~~ICD-9~~] ~~ICD-10~~ Codes to report all diagnoses, reasons for ~~[encounters]~~ encounters, and [~~procedures-based]~~ procedures based upon code level changes made effective October 1 of each year or other effective date designated by the [~~HCFA.~~] CMS.

(2) HCPCS Level [~~1 and 2~~] I and II [~~Codes--based]~~ Codes based upon code level changes made effective October 1 of each year or other effective date designated by the [~~HCFA.~~] CMS.

(3) CPT-4 Codes based upon code level changes made effective January 1 of each year or other effective date designated by the [~~HCFA.~~] CMS.

~~[(e)~~](d) When there is no applicable HCPCS [~~Level 1~~] Level I or [~~Level 2~~] Level II Code or modifier, the payor may establish its own code or modifier. A complete list of all codes and modifiers established by payors [~~must~~] shall be published by and available upon request from ~~payors by January 1, 1995.~~ payors.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Amended Eff. ~~March 1, 1995.~~ March 1, 1995;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1503 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1503 REQUIREMENTS FOR USE OF [~~HCFA~~] CMS FORM 1500

(a) [~~Effective January 1, 1995, the~~] The [~~HCFA~~] CMS Form 1500 shall be the standard claim form for all manual individual health care provider billing, and the [~~HCFA~~] CMS Form 1500 shall be accepted by all payors conducting business in this State.

~~[(b) Effective January 1, 1995, with implementation to be complete no later than April 1, 1995, the following additional information and placement location shall be required for the CMS Form 1500:~~

~~(1) The provider tax I.D. number shall be located in form locator 25.~~

~~(2) The ethnic origin code shall be located in form locator 1a as the subsequent set of numbers in that form locator; the first set of numbers being the insured's I.D. number. Codes X1-X5 (see definitions as defined in the State Uniform Billing Manual), to translate the ethnic origin codes, shall be used to designate the ethnic origin and preceded by the symbol "/".]~~

~~[(c)]~~ (b) Payors may require individual health care providers to use only the following coding system for the filing of claims for health care services:

(1) ICD-9-CM Codes to report all diagnoses, reasons for [~~encounters~~] encounters, and [~~procedures based~~] procedures based upon code level changes made effective October 1 of each year or other effective date designated by the [~~HCFA.~~] CMS.

(2) HCPCS [~~Level 1~~] Level I and [~~Level 2~~] Level II [~~Codes based~~] Codes based upon code level changes made effective October 1 of each year or other effective date designated by the [~~HCFA.~~] CMS.

(3) CPT-4 Codes based upon code level changes made effective January 1 of each year or other effective date designated by the [~~HCFA.~~] CMS.

~~[(d)]~~ (c) When there is no applicable HCPCS [~~Level 1~~] Level I or [~~Level 2~~] Level II Code or modifier, the payor [~~may~~] shall establish its own code or modifier. A complete list of all codes and modifiers established by payors [~~must~~] shall be published by and available upon request from [~~payors by January 1, 1995.~~] payors.

~~[(e)]~~ (d) Type of service codes may not be [~~used after December 31, 1995.~~] used.

~~[(f)]~~ (e) Place of service codes and descriptions shall be recognized by all payors processing claims for services rendered in North [~~Carolina on and after January 1, 1996.~~] Carolina.

~~[(g)]~~ (f) [~~Both~~][~~HCFA~~] CMS physician and specialty codes [~~and North Carolina Board of Medical Examiners specialty definitions~~] shall be recognized by payors processing claims for services rendered in North [~~Carolina on and after January 1, 1996.~~] Carolina.

~~[(h) A Uniform Billing Manual, similar to the concept used by the SUBC for HCFA Form 1450 (UB92), shall be developed to set forth HCFA Form 1500 standards by August 1, 1995. The SUBC, along with the North Carolina Medical Society, may develop and recommend a Uniform Billing Manual to the Commissioner by August 1, 1995. This manual may include standards established by the National Uniform Billing Committee as reflected in its ANSI 837 Guide to be released in February of 1995.]~~

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Amended Eff. ~~February 1, 1995.~~ February 1, 1995;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1504 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1504 REQUIREMENTS FOR USE OF THE CURRENT ADA DENTAL CLAIM FORM

[~~(a)~~] [~~Effective January 1, 1995, with implementation to be complete no later than April 1, 1995,~~] Dentists shall use the current ADA Dental Claim Form and instructions for all manual claims filing with payors. The ADA Dental Claim Form is hereby incorporated by reference, including subsequent amendments and additions, and is available at no cost at https://www.ada.org/en/publications/cdt/ada-dental-claim-form.

~~[(1) The provider tax I.D. number shall be located in form locator 18.]~~

~~[(2) The ethnic origin code shall be located in form locator 31 using Code X1-X5 (see definitions as defined in the State Uniform Billing Manual), to translate the ethnic origin codes, and shall be the first entry on the first line of that form locator, and it shall be followed by the symbol "/".~~]

~~[(b) A Uniform Billing Manual, similar to the concept used by the SUBC for the HCFA Form 1450 (UB92), shall be developed to set standards for the current ADA Dental Claim Form by August 1, 1995. The North Carolina Dental Society may develop and recommend a Uniform Billing Manual to the Commissioner on or before August 1, 1995.~~]

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Amended Eff. ~~*February 1, 1995.*~~ *February 1, 1995;*
Readopted Eff. May 1, 2020.

11 NCAC 12 .1505 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1505 MANAGED CARE FORMS

(a) As used in this Rule, "managed care plan" includes a health maintenance [~~organization,~~] organization or a preferred provider [~~organization~~] [~~or arrangement, or an exclusive provider panel.~~] organization.

(b) The following managed care forms may be used by managed care plans, but shall not be a part of the standard claim form:

(1) An "out-of-network" justification form shall be used by patients filing claims with their managed care plans when they have to justify the reasons they sought out-of-network health care services. This form shall be standardized, and the managed care plan industry shall develop and file this form with the [~~Commissioner for approval on or before October 1, 1995.~~] Commissioner.

(2) A "patient encounter form and electronic format" shall be used by managed care plans to record and report encounter information. This form shall provide information similar to the [~~HCFA~~] CMS Form 1450 ~~(UB92)~~ (UB-04) and ~~HCFA~~ CMS Form 1500 and shall include information on patient identification, dates of services provided, types of services provided, and identities of health care providers. This form and electronic formats shall be standardized, and the managed care plan industry shall develop and file these with the [~~Commissioner for approval on or before October 1, 1995.~~] Commissioner.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. ~~October 1, 1994.~~ October 1, 1994;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1506 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1506 ELECTRONIC FORMAT STANDARDS

(a) As used in this Rule, "ASC X12 Standard Format" means the standards for electronic data interchange within the health care provider industry developed by the Accredited Standards Committee X12 Insurance Subcommittee of the American National Standards Institute.

(b) Payors and health care providers that receive or generate claims or send payments by electronic means [~~shall, by October 1, 1996,~~] shall accept or generate the appropriate ASC X12 Standard Format for their health care claims submission and remittance transactions. [~~Until the appropriate ASC X12 interactive transaction is approved for implementation, the current standards of the National Council for Prescription Drug Programs shall be the standard format.~~]

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. ~~October 1, 1994.~~ October 1, 1994;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1507 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1507 ATTACHMENT FORM OR FORMAT

(a) As used in this Rule, "attachment form or format" means a form, document, or communication of any kind used by a payor to request additional [~~information~~] information, other than that contained on the standard claim form, from a health care [~~provider,~~] provider in connection with processing a claim for payment.

(b) Payors shall not require the submission of information already contained in the standard claim form.

[~~(b) Effective January 1, 1995, no additional attachment forms or formats may be used except as authorized by this Section. Payors may use local use blocks on the standard claim form or obtain prior approval from the Commissioner to use other information in addition to that contained in the standard claim form.~~]

[~~(c) All attachment forms or formats in use on October 1, 1994, must be submitted by payors to the Commissioner for registration on or before January 1, 1995, and may continue to be used thereafter if they are in compliance with this Section. Payors may not require the submission of information already contained in the standard claim form, or any other information not necessary for the processing of a claim. After January 1, 1995, no additional attachments shall be used unless filed with and approved by the Commissioner. All additional attachments shall be reviewed by the SUBC, which shall make a recommendation to the Commissioner for final consideration~~.]

[~~(d) After consideration and approval by the SUBC, the SUBC may recommend to the Commissioner any changes to the standard claim form once every calendar~~ year quarter beginning January 1, 1995.]

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. ~~October 1, 1994.~~ October 1, 1994;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1508 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1508 MEDICARE SUPPLEMENT PAYORS

~~[Effective October 1, 1996, Medicare]~~ Medicare supplement insurance payors shall electronically interface claims data with the Medicare Section of ~~HCFA.~~CMS.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. ~~October 1, 1994.~~October 1, 1994;
Readopted Eff. May 1, 2020.

11 NCAC 12 .1509 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1509 PATIENT SUBMITTED CLAIM FORMS

The health care provider shall provide a patient the CMS-1500 and UB-04 (CMS-1450) standard claim [~~form~~] forms, [~~shall be provided to any patient by any health care provider~~] if [~~that~~] the patient must submit a claim to a payor. The standard claim form shall be provided as the initial bill for payment of services and [~~will~~] shall be used by the patient to request reimbursement from a payor. Health care providers [~~may~~] shall also continue to provide patients billing statements for subsequent billing of the same services. [~~No payor may~~] A payor shall not require any additional documentation from a patient to support a claim for reimbursement payment by a patient if the information required is already contained on the standard claim form. No payor shall require any patient to submit claims or other information in an electronic format.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. ~~*October 1, 1994.*~~ *October 1, 1994;*
Readopted Eff. May 1, 2020.

11 NCAC 12 .1803 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1803 GENERAL REQUIREMENTS

No insurer shall provide any PPO benefit plan unless it complies with the following:

(1) Where the covered benefits of a PPO benefit plan include coinsurance, the difference in coinsurance rates between in-network covered services and out-of-network covered services shall not exceed 30 percentage points.

(2) If the schedule of benefits for a PPO benefit plan imposes a deductible for in-network covered services, the amount of any separate annual deductible per enrollee or per family for out-of-network covered services may not exceed two times the amount of the annual per enrollee or per family deductible applied to in-network covered services.

(3) If the schedule of benefits for a PPO benefit plan does not include an annual deductible for in-network covered services, the annual deductibles for out-of-network covered services shall not exceed two hundred and fifty dollars ($250.00) per enrollee and the family deductible may not exceed seven hundred and fifty dollars ($750.00).

(4) The portion of any charge for out-of-network covered services to be applied to an annual deductible may be based on actual charges or the insurer's usual and customary charges.

(5) If there are benefit maximums for in-network covered services, the amount of any annual and lifetime maximum limits for out-of-network covered services shall not be less than one-half of the amount of any annual and lifetime maximum limits for in-network covered services.

(6) If a PPO benefit plan includes copayments for both in-network covered services and out-of-network covered services, the amount of the copayment for an out-of-network covered service shall not exceed the copayment for an in-network covered service by more than twenty dollars ($20.00) or 100%, whichever is greater.

(7) If the schedule of benefits for a PPO benefit plan limits the annual out-of-pocket expenses of enrollees to a maximum amount for in-network covered services, the amount of any separate annual out-of-pocket maximum for out-of-network covered services may not exceed two times the maximum amount for in-network covered services.

(8) If the schedule of benefits for a PPO benefit plan does not include an annual maximum limit on out-of-pocket expenses for in-network covered services, the maximum limit on out-of-pocket expenses for out-of-network covered services shall not exceed one thousand two hundred and fifty dollars ($1,250) per enrollee or three thousand seven hundred and fifty dollars ($3,750) per family.

(9) An insurer offering a PPO benefit plan may limit coverage for annual physicals and health screenings performed for preventative purposes to those services provided on an in-network basis, except that services provided in connection with mandated benefits must be available on both an in-network and out-of-network basis. An insurer shall provide coverage on both an in-network and out-of-network basis for all other covered services.

(10) PPO benefit plans shall give enrollees the option to choose in-network covered services or out-of-network covered services each time those covered services are authorized, obtained, or rendered; and shall not require enrollees to obtain insurer approval to exercise that option.

(11) An insurer offering a PPO benefit plan shall not impose different medical management requirements, including utilization review criteria or prior approval requirements, for out-of-network covered services than are imposed on in-network covered services. Those medical management requirements shall not restrict enrollees' abilities to seek covered services on out-of-network bases.

History Note: *Authority G.S. 58-2-40; 58-50-56;*
Temporary Adoption Eff. January 1, 1998;
Eff. ~~August 1, 1998.~~ August 1, 1998;
Readopted Eff. May 1, 2020.

STATE OF NORTH CAROLINA
OFFICE OF ADMINISTRATIVE HEARINGS

Mailing address:
6714 Mail Service Center
Raleigh, NC 27699-6700

Street address:
1711 New Hope Church Rd
Raleigh, NC 27609-6285

February 20, 2020

Loretta Peace-Bunch
Sent via email only to: Loretta.Peace-Bunch@ncdoi.gov

Re: Extension of the Period of Review for Rules 11 NCAC 12 .0321, .0514, .1501-.1509, and .1803

Dear Ms. Peace-Bunch:

At its meeting this morning, the Rules Review Commission extended the period of review for the above-captioned rules in accordance with G.S. 150B-21.10. They did so in response to a request from the Department of Insurance to extend the period in order to allow the agency to address the requested technical changes and submit the revised rules at a later meeting.

Pursuant to G.S. 150B-21.13, when the Commission extends the period of review, it is required to approve or object to rules or call a public hearing on the same within 70 days.

If you have any questions regarding the Commission's actions, please let me know.

Sincerely,

Ashley Snyder
Commission Counsel

cc: John Hoomani, John.Hoomani@ncdoi.gov

Burgos, Alexander N

Subject: FW: Extension of period of review

From: Peace-Bunch, Loretta Y <loretta.peace-bunch@ncdoi.gov>
Sent: Thursday, February 6, 2020 3:50 PM
To: Snyder, Ashley B <ashley.snyder@oah.nc.gov>
Cc: Hoomani, A. John <john.hoomani@ncdoi.gov>
Subject: Extension of period of review

Ashley,

The Department of Insurance is requesting an extension of the period of review for all of the Chapter 12 rules that are up for readoption. Please let us know if more information is needed.

Thank you,
Loretta

Loretta Peace-Bunch | Rules Coordinator

N.C. Department of Insurance
325 N. Salisbury Street
Raleigh, NC 27603

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: All Rules

DEADLINE FOR RECEIPT: February 10, 2020

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

On your Submission for Permanent Rule Forms, please provide an adoption date in box 6.

Throughout these rules, the citations and statutory authority are to North Carolina General Statutes. Is any of this governed by federal law in addition to the State statutes? Does the authority for any of these rules come from federal law or federal regulations?

Throughout these Rules, you reference many forms and billing codes created by other agencies or organizations. Are the names of the forms and billing codes all up to date?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

RRC STAFF OPINION

PLEASE NOTE: THIS COMMUNICATION IS EITHER 1) ONLY THE RECOMMENDATION OF AN RRC STAFF ATTORNEY AS TO ACTION THAT THE ATTORNEY BELIEVES THE COMMISSION SHOULD TAKE ON THE CITED RULE AT ITS NEXT MEETING, OR 2) AN OPINION OF THAT ATTORNEY AS TO SOME MATTER CONCERNING THAT RULE. THE AGENCY AND MEMBERS OF THE PUBLIC ARE INVITED TO SUBMIT THEIR OWN COMMENTS AND RECOMMENDATIONS (ACCORDING TO RRC RULES) TO THE COMMISSION.

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .0321

RECOMMENDED ACTION:

Approve, but note staff's comment

X Object, based on:

Lack of statutory authority

X Unclear or ambiguous

Unnecessary

Failure to comply with the APA

Extend the period of review

COMMENT:

Staff recommends objection for lack of clarity. Specifically, line 5 provides a cross-reference to Rule 11 NCAC 12 .0307 which has been repealed. As a result, the filing requirements for schedules of premiums are unclear. Additionally, the Rule is ambiguous as written since it uses the undefined terms "excessive," "inadequate" and "unfairly discriminatory" at line 10 as well as the phrase "data deemed necessary by the commissioner" at line 12.

Ashley Snyder
Commission Counsel

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .0321

DEADLINE FOR RECEIPT: February 10, 2020

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

In (a), how are the schedules required to be filed? The rule referenced at line 5 has been repealed. Please review and update.

In (a), are the schedules still required to be filed "in duplicate" or are they now submitted electronically? The same question applies for the "triplicate" copies required at line 14.

In (b)(1) and (2), what do you mean by "a certification?"

At line 8, please say "his or her."

In (b)(2), what is an "actuarial expert?" Are you requiring an actuary with a specific certification or license?

In (b)(2), please consider changing "such" to "the."

At line 10, define "excessive," "inadequate," and "unfairly discriminatory." What are you requiring here?

In (b)(3), are you requiring the submission of any specific data?

In (b)(4), under what circumstances is additional data "deemed necessary?"

In (b)(4), line 12, should "Commissioner" be capitalized?

In (c), the Rule says, "rates required by this Rule shall be filed in triplicate." What are "rates?" Are they the same or different than "premiums?" If they are different, this Rule does not require the filing of rates. If they are the same, you require a duplicate filing of premiums at line 4, but a triplicate filing of rates at line 14. Please clarify.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

11 NCAC 12 .0321 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .0321 RATE FILING: HMO

(a) All schedules of premiums for enrollee coverage for health care services, or amendment thereto, shall be filed in duplicate in accordance with 11 NCAC 12 .0307(b)(5), indicating whether the schedule is original or amended.

(b) All filings shall be accompanied by:

(1) A certification by the chief executive officer of the corporation that the premiums applicable to an enrollee are not individually determined based on the status of his health;

(2) A certification by an actuarial expert that such premiums are established in accordance with actuarial principles for various categories of enrollees and are not excessive, inadequate, or unfairly discriminatory;

(3) Actuarial data supporting the schedule of premiums;

(4) Such other data deemed necessary by the commissioner to determine whether to approve or disapprove the filing;

(c) Actuarial data and rates required by this Rule shall be filed in triplicate.

History Note: *Authority G.S. 58-67-50; 58-67-150;*
Eff. January 22, 1980;
Amended Eff. ~~February 1, 1992.~~ February 1, 1992;
Readopted Eff. March 1, 2020.

RRC STAFF OPINION

PLEASE NOTE: THIS COMMUNICATION IS EITHER 1) ONLY THE RECOMMENDATION OF AN RRC STAFF ATTORNEY AS TO ACTION THAT THE ATTORNEY BELIEVES THE COMMISSION SHOULD TAKE ON THE CITED RULE AT ITS NEXT MEETING, OR 2) AN OPINION OF THAT ATTORNEY AS TO SOME MATTER CONCERNING THAT RULE. THE AGENCY AND MEMBERS OF THE PUBLIC ARE INVITED TO SUBMIT THEIR OWN COMMENTS AND RECOMMENDATIONS (ACCORDING TO RRC RULES) TO THE COMMISSION.

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .0514

RECOMMENDED ACTION:

Approve, but note staff's comment

X Object, based on:

Lack of statutory authority

X Unclear or ambiguous

Unnecessary

Failure to comply with the APA

Extend the period of review

COMMENT:

Staff recommends objection to this Rule governing selection of benefits for accident and health insurance for lack of clarity. This Rule is unclear as written for many reasons, including use of the defined terms "plan" at line 18 and "this plan" at line 30 in addition to the undefined terms "separate plan" at line 28 and "other plan" on page 2, line 30. Staff notes the term is partially capitalized as "other Plan" on page 2, line 15, so it is additionally unclear if this term has a different meaning. The multiple versions and meanings of the word "plan" used throughout this Rule make the Rule confusing and thus, ambiguous as written.

At line 11, this Rule states, ". . . the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan." It is unclear to staff whether "the order of benefit determination rules" refers to Item (3) of this Rule or Sub-item (3)(b) of this Rule. The term "rule" also appears to refer to requirements within specific "plans" at page 2, lines 30-32. The multiple uses of the word "rule," none of which follow the definition of the term in G.S. 150B-2(8a), further confuse the meaning of this Rule.

The Rule also includes the following undefined terms which make the Rule unclear: "school accident-type coverage" at line 21; "parts" at line 29; the phrase "necessary, reasonable, and customary" at page 2, line 1; "services" at page 2, line 3; and "necessary medical expenses" at page 2, line 5. Overall, staff recommends objection for ambiguity.

Ashley Snyder
Commission Counsel

11 NCAC 12 .0514 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .0514 COORDINATION: GROUP A/H CONTRACT BENEFITS: GROUP COVERAGES

Purpose. In order to promote consistency in liability for claims and claims determination for Group Accident and Health coverage, the department shall require a uniform order of benefits determination as follows:

(1) Applicability:

(a) This Coordination of Benefits ("COB") provision applies to this plan when a employee or the employee's covered dependent has health care coverage under more than one plan. "Plan" and "This Plan" are defined in (2)(a) and (b) of this Rule.

(b) If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

(i) Shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan; but

(ii) May be reduced when, under the order of benefit determination rules, another plan determines its Section (IV) Effect on the Benefits of this plan.

(2) Definitions:

(a) A "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

(i) True group insurance. This includes prepayment, group practice or individual practice coverage. It does not include school accident-type coverage, blanket, franchise individual, automobile and homeowner coverage.

(ii) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage under (2)(a) (i) or (ii) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

(b) "This Plan" is the part of the group contact that provides benefits for health care expenses.

(c) "Primary Plan"/"Secondary Plan". The order of benefit determination rules state whether this plan is a Primary Plan or Secondary Plan as to another plan covering the person. When this plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When there are more than two plans covering the person, this plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

(d) "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid. Total benefits paid must be equal to 100 percent of necessary medical expenses covered by both plans.

(e) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or any part of a year before the date this COB provision or a similar provision takes effect.

(3) Order of Benefit Determination Rules:

(a) General. When there is a basis for a claim under this plan and another plan, this plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

(i) the other plan has rules coordinating its benefits with those of this plan; and

(ii) both those rules and this plan's rules, in (3)(b)(ii)(B) of this Rule, require that this plan's benefits be determined before those of the other Plan.

(b) Rules. This plan determines its order of benefits using the first of the following rules which applies:

(i) Non-dependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

(ii) Dependent Child/Parents Not Separated or Divorced. Except as stated in (3)(b)(iii)(B) of this Rule, when this plan and another plan cover the same child as a dependent of different persons, called "parents":

(A) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

(B) if both parents have the same birthday, the benefits of the plan that has covered a parent for a longer period of time are determined before those of the plan that covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in Paragraph (3)(a) in this Rule, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(iii) Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(A) first, the plan of the parent with custody of the child;

(B) then, the plan of the spouse of the parent with custody of the child; and

(C) finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. In this Rule, (3)(b)(iii)(C) does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(iv) Active Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have (3)(b)(iv), and if, as a result, the plans do not agree on the order of benefits, (3)(b)(iv) is ignored.

(v) Longer/Shorter Length of Coverage. If more of Paragraph (3) of this Rule determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

History Note: *Authority G.S. 58-2-40; 58-51-1; 58-65-1; 58-65-40;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1992; April 1, 1989; ~~July 1, 1986.~~ July 1, 1986;
Readopted Eff. March 1, 2020.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .1501

DEADLINE FOR RECEIPT: February 10, 2020

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

At line 6, please delete or define "clearly."

In (1), is the Fourth Edition still current?

In (4) and (5), please incorporate the forms by reference since Rules .1502 and .1503 require use of these forms. G.S. 150B-2(8a)(d) requires the contents or substantive requirements of a form to be in rule.

In (8), line 30, is the Ninth Revision still current?

In (9), line 32, what do you mean by "natural person?"

In (10), lines 2-5, do you mean "as defined in" instead of "as licensed under?" The referenced statutes are definitions.

In (10)(b), did you intend to refer to G.S. 131E-176(1b)?

In (13), what is the State Uniform Billing Committee? Is it a State government agency?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

11 NCAC 12 .1501 is readopted as published in NCR 34:10 839 as follows:

SECTION .1500 - UNIFORM CLAIM FORMS

11 NCAC 12 .1501 DEFINITIONS

In this Section, unless the context clearly indicates otherwise:

(1) "CPT-4 Codes" means the Physician Current Procedural Terminology, Fourth Edition, published by the American Medical Association.

(2) "Current ADA Dental Claim Form" means the most recent health insurance claim form published by the American Dental Association.

(3) "Ethnic origin code" is the established Ethnic (Race) Code as used by the Economics and Statistics Administration, Bureau of Labor Statistics, U.S. Department of Commerce.

(4) "HCFA" means the Health Care Financing Administration of the U.S. Department of Health and Human Services.

(5) "HCFA Form 1450 (UB92)" means the health insurance claim form published by the HCFA for use by institutional health care providers.

(6) "HCFA Form 1500" means the health insurance claim form published by the HCFA for use by individual health care providers.

(7) "HCPCS" means HCFA's Common Procedure Coding System, a coding system that describes products, supplies, procedures, and health care provider services; and includes the CPT-4 Codes, alphanumeric codes, and related modifiers. HCPCS includes:

(a) "HCPCS Level 1 Codes", which are the CPT-4 codes and modifiers for professional services and procedures;

(b) "HCPCS Level 2 Codes", which are national alphanumeric codes and modifiers for health care products and suppliers, as well as some codes for professional services not included in the CPT-4 Codes;

(c) "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.

(8) "ICD-9-CM Codes" means the diagnosis and procedure codes in the International Classification of Diseases, Ninth Revision, Clinical Modifications, published by the U.S. Department of Health and Human Services.

(9) "Individual health care provider" includes any individual, natural person who, under Chapter 90 of the General Statutes is licensed, registered, or certified to engage in the practice of or performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, or psychology.

(10) "Institutional health care provider" includes:

(a) a hospital licensed under G.S. 131E-176(13);

(b) an ambulatory surgical facility licensed under G.S. 131E-176(1a);

(c) a health service facility licensed under G.S. 131E-176(9b);

(d) a home health agency licensed under G.S. 131E-176(12);

(e) any of the entities listed in G.S. 58-55-35.

(11) "Payor" means an entity that provides a "health benefit plan", as defined in G.S. 58-3-171(c).

(12) "Standard claim form" means the HCFA Form 1450 (UB92), HCFA Form 1500, or the current ADA Dental Claim Form.

(13) "SUBC" means the North Carolina State Uniform Billing Committee.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. ~~October 1, 1994.~~ October 1, 1994;
Readopted Eff. March 1, 2020.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .1502

DEADLINE FOR RECEIPT: February 10, 2020

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

In (a), is it still necessary to say "Effective January 1, 1995?"

In (b), line 6, is it still necessary to say "Effective January 1, 1995, with implementation to be complete no later than April 1, 1995?"

At line 10, what do you mean by "(see definitions as defined in the State Uniform Billing Manual)?"

In (c), line 11, is it still necessary to say "Effective October 1, 1995?"

At line 13, does this include urgent care facilities?

At lines 15-19, is this still how your regulated public can access this publication? Is it now available online? If not, is the cost still $25?

In (d), line 20, do you mean "may" or "shall?"

At line 22, should there be a comma after "encounters?"

At lines 22 and 24, please consider deleting the dashes after "procedures" and "Codes."

In (d)(1)-(3), when you say "or other effective date designated by the HCFA" are you referring to a set, yearly designation at a different date or can the HCFA make code level changes with an effective date at any time?

At line 28, do you mean "may" or "shall?"

At line 29, please change "must" to "shall."

At line 20, is it still necessary to say "by January 1, 1995?"

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

11 NCAC 12 .1502 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1502 REQUIREMENTS FOR USE OF HCFA FORM 1450 (UB92)

(a) Effective January 1, 1995, the HCFA Form 1450 (UB92) shall be the standard claim form for all manual billing by institutional health care providers, and the HCFA Form 1450 shall be accepted by all payors conducting business in this State.

(b) Effective January 1, 1995, with implementation to be complete no later than April 1, 1995, the following additional information and placement location shall be required for the HCFA Form 1450 (UB92):

(1) The provider tax I.D. number shall be located in form locator 5.

(2) The ethnic origin code shall be located in form locator 24-30 (Condition Codes), using Code X1-X5 (see definitions as defined in the State Uniform Billing Manual) to translate the ethnic origin codes.

(c) Effective October 1, 1995, the cause of injury code shall be located in form locator 77. This code shall be required on all HCFA Form 1450 (UB92) claims generated by institutional health care providers for claims of inpatients and of patients treated in emergency rooms or trauma centers; and where the diagnosis includes an injury diagnosis, which means a diagnostic code in the range or 800-999 as defined in the ICD-9 coding manual. Coding of the cause of injury shall be in accordance with the standards in the publication entitled, "Coding and Reporting of External Causes of Injury and Poisoning Recommended Coding Guidelines for ICD-9-CM", which standards are incorporated by reference into this Rule, including subsequent amendments and editions. Copies of the publication can be obtained from the Center for Health Policy Studies, 9700 Patuxent Woods Drive, Columbia, Maryland 21046-1577, for twenty five dollars ($25.00) each. The absence of this code may not be used to deny the payment of a claim.

(d) Payors may require institutional health care providers to use only the following coding systems for the filing of claims for health care services:

(1) ICD-9-CM Codes to report all diagnoses, reasons for encounters and procedures - based upon code level changes made effective October 1 of each year or other effective date designated by the HCFA.

(2) HCPCS Level 1 and 2 Codes - based upon code level changes made effective October 1 of each year or other effective date designated by the HCFA.

(3) CPT-4 Codes based upon code level changes made effective January 1 of each year or other effective date designated by the HCFA.

(e) When there is no applicable HCPCS Level 1 or Level 2 Code or modifier, the payor may establish its own code or modifier. A complete list of all codes and modifiers established by payors must be published by and available upon request from payors by January 1, 1995.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Amended Eff. ~~March 1, 1995.~~ March 1, 1995;
Readopted Eff. March 1, 2020.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .1503

DEADLINE FOR RECEIPT: February 10, 2020

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

In (a), is it still necessary to say "effective January 1, 1995?"

In (b), is it still necessary to say "effective January 1, 1995 with implementation to be complete no later than April 1, 1995?"

In (b)(2), lines 10-11, what do you mean by "(see definitions as defined in the State Uniform Billing Manual)?"

At line 15, should there be a comma after "encounters?"

At lines 15 and 17, please delete the dashes after "procedures" and "Codes."

In (c)(1)-(3), when you say "or other effective date designated by the HCFA" are you referring to a set, yearly designation at a different date or can the HCFA make code level changes with an effective date at any time?

At line 21, do you mean "may" or "shall?"

At line 22, please change "must" to "shall."

At line 23, is it still necessary to say "by January 1, 1995?"

In (e), is it still necessary to say "after December 31, 1995?" If not, please consider saying "Type of service codes shall not be used."

In (f), is it still necessary to say "on and after January 1, 1996?"

In (g), line 27, what are the "North Carolina Board of Medical Examiners specialty definitions?" Are they established in rule?

At line 28, is it still necessary to say "on and after January 1, 1996?"

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

Is (h) still necessary?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

11 NCAC 12 .1503 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1503 REQUIREMENTS FOR USE OF HCFA FORM 1500

(a) Effective January 1, 1995, the HCFA Form 1500 shall be the standard claim form for all manual individual health care provider billing, and the HCFA Form 1500 shall be accepted by all payors conducting business in this State.

(b) Effective January 1, 1995, with implementation to be complete no later than April 1, 1995, the following additional information and placement location shall be required for the HCFA Form 1500:

(1) The provider tax I.D. number shall be located in form locator 25.

(2) The ethnic origin code shall be located in form locator 1a as the subsequent set of numbers in that form locator; the first set of numbers being the insured's I.D. number. Codes X1-X5 (see definitions as defined in the State Uniform Billing Manual), to translate the ethnic origin codes, shall be used to designate the ethnic origin and preceded by the symbol "/".

(c) Payors may require individual health care providers to use only the following coding system for the filing of claims for health care services:

(1) ICD-9-CM Codes to report all diagnoses, reasons for encounters and procedures - based upon code level changes made effective October 1 of each year or other effective date designated by the HCFA.

(2) HCPCS Level 1 and 2 Codes - based upon code level changes made effective October 1 of each year or other effective date designated by the HCFA.

(3) CPT-4 Codes based upon code level changes made effective January 1 of each year or other effective date designated by the HCFA.

(d) When there is no applicable HCPCS Level 1 or Level 2 Code or modifier, the payor may establish its own code or modifier. A complete list of all codes and modifiers established by payors must be published by and available upon request from payors by January 1, 1995.

(e) Type of service codes may not be used after December 31, 1995.

(f) Place of service codes and descriptions shall be recognized by all payors processing claims for services rendered in North Carolina on and after January 1, 1996.

(g) Both HCFA physician and specialty codes and North Carolina Board of Medical Examiners specialty definitions shall be recognized by payors processing claims for services rendered in North Carolina on and after January 1, 1996.

(h) A Uniform Billing Manual, similar to the concept used by the SUBC for HCFA Form 1450 (UB92), shall be developed to set forth HCFA Form 1500 standards by August 1, 1995. The SUBC, along with the North Carolina Medical Society, may develop and recommend a Uniform Billing Manual to the Commissioner by August 1, 1995. This manual may include standards established by the National Uniform Billing Committee as reflected in its ANSI 837 Guide to be released in February of 1995.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Amended Eff. ~~February 1, 1995.~~ February 1, 1995;

Readopted Eff. March 1, 2020.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .1504

DEADLINE FOR RECEIPT: February 10, 2020

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Where is your statutory authority to establish a uniform claim form for dental claims? Is dental insurance included in the definition of "health benefits plans" in G.S. 58-3-171?

At line 4, is it still necessary to say "Effective January 1, 1995, with implementation to be complete no later than April 1, 1995?"

At lines 4-5, what is the "current ADA Dental Claim Form?" Is it in rule in accordance with G.S. 150B-2(8a)(d)? How can it be accessed? Please consider incorporating this form by reference.

At lines 7-8, what do you mean by "(see definitions as defined in the State Uniform Billing Manual)?"

Is (b) still necessary?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

11 NCAC 12 .1504 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1504 REQUIREMENTS FOR USE OF THE CURRENT ADA DENTAL CLAIM FORM

(a) Effective January 1, 1995, with implementation to be complete no later than April 1, 1995, Dentists shall use the current ADA Dental Claim Form and instructions for all manual claims filing with payors.

(1) The provider tax I.D. number shall be located in form locator 18.

(2) The ethnic origin code shall be located in form locator 31 using Code X1-X5 (see definitions as defined in the State Uniform Billing Manual), to translate the ethnic origin codes, and shall be the first entry on the first line of that form locator, and it shall be followed by the symbol "/".

(b) A Uniform Billing Manual, similar to the concept used by the SUBC for the HCFA Form 1450 (UB92), shall be developed to set standards for the current ADA Dental Claim Form by August 1, 1995. The North Carolina Dental Society may develop and recommend a Uniform Billing Manual to the Commissioner on or before August 1, 1995.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. October 1, 1994;
Amended Eff. ~~February 1, 1995.~~ February 1, 1995;
Readopted Eff. March 1, 2020.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .1505

DEADLINE FOR RECEIPT: February 10, 2020

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

At line 4, are you using the term "preferred provider organization" as defined in G.S. 58-50-56(a)(4)?

At line 5, please define "exclusive provider panel."

In (b), line 6, do you mean "shall" instead of "may?" You use "shall" at lines 7 and 11.

In (b)(1), are the contents or substantive requirements of the out-of-network justification form in rule in accordance with G.S. 150B-2(8a)(d)?

In (b)(2), are the contents or substantive requirements of the patient encounter form in rule in accordance with G.S. 150B-2(8a)(d)?

In (b)(2), lines 11 and 14, what do you mean by "electronic formats?" Do you mean this form shall be available electronically?

At line 10, is it still necessary to say "on or before October 1, 1995?"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

11 NCAC 12 .1505 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1505 MANAGED CARE FORMS

(a) As used in this Rule, "managed care plan" includes a health maintenance organization, a preferred provider organization or arrangement, or an exclusive provider panel.

(b) The following managed care forms may be used by managed care plans, but shall not be a part of the standard claim form:

(1) An "out-of-network" justification form shall be used by patients filing claims with their managed care plans when they have to justify the reasons they sought out-of-network health care services. This form shall be standardized, and the managed care plan industry shall develop and file this form with the Commissioner for approval on or before October 1, 1995.

(2) A "patient encounter form and electronic format" shall be used by managed care plans to record and report encounter information. This form shall provide information similar to the HCFA Form 1450 (UB92) and HCFA Form 1500 and shall include information on patient identification, dates of services provided, types of services provided, and identities of health care providers. This form and electronic formats shall be standardized, and the managed care plan industry shall develop and file these with the Commissioner for approval on or before October 1, 1995.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. ~~October 1, 1994.~~ October 1, 1994;
Readopted Eff. March 1, 2020.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .1506

DEADLINE FOR RECEIPT: February 10, 2020

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

In (b), lines 7-8, is it still necessary to say "by October 1, 1996?"

At line 8, please delete or define "appropriate."

At lines 9-10, is the last sentence of this Rule still necessary?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

11 NCAC 12 .1506 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1506 ELECTRONIC FORMAT STANDARDS

(a) As used in this Rule, "ASC X12 Standard Format" means the standards for electronic data interchange within the health care provider industry developed by the Accredited Standards Committee X12 Insurance Subcommittee of the American National Standards Institute.

(b) Payors and health care providers that receive or generate claims or send payments by electronic means shall, by October 1, 1996, accept or generate the appropriate ASC X12 Standard Format for their health care claims submission and remittance transactions. Until the appropriate ASC X12 interactive transaction is approved for implementation, the current standards of the National Council for Prescription Drug Programs shall be the standard format.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. ~~October 1, 1994.~~ October 1, 1994;
Readopted Eff. March 1, 2020.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .1507

DEADLINE FOR RECEIPT: February 10, 2020

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

At line 5, consider adding a comma after "information" and deleting the comma after "provider."

In (b), is it still necessary to say "effective January 1, 1995?"

In (b), line 7, do you mean "may" or "shall."

At line 8, do you mean "may" or "shall."

At line 8, under what circumstances does the Commissioner grant prior approval?

At lines 8-9, do you mean "to use other information" or "to request other information?"

In (c), lines 10-11, is this sentence still necessary?

At line 12, do you mean "may" or "shall?"

At line 13, what information is "not necessary" for the processing of a claim? Who makes this determination? What factors are considered?

At line 13, is it still necessary to say "After January 1, 1995?"

At lines 13-14, under what circumstances will the Commissioner approve an attachment? What factors are considered?

How does the requirement for approval by the Commissioner at line 14 differ from the requirement for prior approval from the Commissioner at line 8? Is this repetitive?

In (d), line 17, is it still necessary to say "beginning January 1, 1995?"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

11 NCAC 12 .1507 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1507 ATTACHMENT FORM OR FORMAT

(a) As used in this Rule, "attachment form or format" means a form, document, or communication of any kind used by a payor to request additional information other than that contained on the standard claim form, from a health care provider, in connection with processing a claim for payment.

(b) Effective January 1, 1995, no additional attachment forms or formats may be used except as authorized by this Section. Payors may use local use blocks on the standard claim form or obtain prior approval from the Commissioner to use other information in addition to that contained in the standard claim form.

(c) All attachment forms or formats in use on October 1, 1994, must be submitted by payors to the Commissioner for registration on or before January 1, 1995, and may continue to be used thereafter if they are in compliance with this Section. Payors may not require the submission of information already contained in the standard claim form, or any other information not necessary for the processing of a claim. After January 1, 1995, no additional attachments shall be used unless filed with and approved by the Commissioner. All additional attachments shall be reviewed by the SUBC, which shall make a recommendation to the Commissioner for final consideration.

(d) After consideration and approval by the SUBC, the SUBC may recommend to the Commissioner any changes to the standard claim form once every calendar year quarter beginning January 1, 1995.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. ~~October 1, 1994.~~ October 1, 1994;
Readopted Eff. March 1, 2020.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .1508

DEADLINE FOR RECEIPT: February 10, 2020

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Do you have statutory authority for this Rule given G.S. 58-3-7?

At line 4, is it still necessary to say "effective October 1, 1996?"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

11 NCAC 12 .1508 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1508 MEDICARE SUPPLEMENT PAYORS

Effective October 1, 1996, Medicare supplement insurance payors shall electronically interface claims data with the Medicare Section of HCFA.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. ~~October 1, 1994.~~October 1, 1994;
Readopted Eff. March 1, 2020.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .1509

DEADLINE FOR RECEIPT: February 10, 2020

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

At line 4, which form is the "standard claim form?"

In the first sentence, please consider re-wording to say who shall do what. Consider: "The health care provider shall provide a patient the standard claim form, [insert form name], if the patient needs to submit a claim to a payor."

At line 5, please change "will" to "shall."

At line 6, do you mean "may" or "shall?"

At line 7, please consider replacing "No payor may require" with "A payor shall not."

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

11 NCAC 12 .1509 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1509 PATIENT SUBMITTED CLAIM FORMS

The standard claim form shall be provided to any patient by any health care provider if that patient must submit a claim to a payor. The standard claim form shall be provided as the initial bill for payment of services and will be used by the patient to request reimbursement from a payor. Health care providers may also continue to provide patients billing statements for subsequent billing of the same services. No payor may require any additional documentation from a patient to support a claim for reimbursement payment by a patient if the information required is already contained on the standard claim form. No payor shall require any patient to submit claims or other information in an electronic format.

History Note: *Authority G.S. 58-2-40; 58-3-171;*
Eff. ~~October 1, 1994.~~ October 1, 1994;
Readopted Eff. March 1, 2020.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .1803

DEADLINE FOR RECEIPT: February 10, 2020

***PLEASE NOTE:* This request may extend to several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

At line 5, does your regulated public understand the meaning of "coinsurance?"

In (4), line 16, do you mean "may" or "shall?"

In (9), line 35, under what circumstances are services "provided in connection with mandated benefits?" What are "mandated benefits?" Please clarify.

In (10), line 2, please consider ending the sentence after "rendered" and beginning a new sentence: "PPO benefit plans shall not require . . ."

Does this Rule comply with G.S. 58-3-200(d)?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Ashley Snyder
Commission Counsel
Date submitted to agency: January 27, 2020

11 NCAC 12 .1803 is readopted as published in NCR 34:10 839 as follows:

11 NCAC 12 .1803 GENERAL REQUIREMENTS

No insurer shall provide any PPO benefit plan unless it complies with the following:

(1) Where the covered benefits of a PPO benefit plan include coinsurance, the difference in coinsurance rates between in-network covered services and out-of-network covered services shall not exceed 30 percentage points.

(2) If the schedule of benefits for a PPO benefit plan imposes a deductible for in-network covered services, the amount of any separate annual deductible per enrollee or per family for out-of-network covered services may not exceed two times the amount of the annual per enrollee or per family deductible applied to in-network covered services.

(3) If the schedule of benefits for a PPO benefit plan does not include an annual deductible for in-network covered services, the annual deductibles for out-of-network covered services shall not exceed two hundred and fifty dollars ($250.00) per enrollee and the family deductible may not exceed seven hundred and fifty dollars ($750.00).

(4) The portion of any charge for out-of-network covered services to be applied to an annual deductible may be based on actual charges or the insurer's usual and customary charges.

(5) If there are benefit maximums for in-network covered services, the amount of any annual and lifetime maximum limits for out-of-network covered services shall not be less than one-half of the amount of any annual and lifetime maximum limits for in-network covered services.

(6) If a PPO benefit plan includes copayments for both in-network covered services and out-of-network covered services, the amount of the copayment for an out-of-network covered service shall not exceed the copayment for an in-network covered service by more than twenty dollars ($20.00) or 100%, whichever is greater.

(7) If the schedule of benefits for a PPO benefit plan limits the annual out-of-pocket expenses of enrollees to a maximum amount for in-network covered services, the amount of any separate annual out-of-pocket maximum for out-of-network covered services may not exceed two times the maximum amount for in-network covered services.

(8) If the schedule of benefits for a PPO benefit plan does not include an annual maximum limit on out-of-pocket expenses for in-network covered services, the maximum limit on out-of-pocket expenses for out-of-network covered services shall not exceed one thousand two hundred and fifty dollars ($1,250) per enrollee or three thousand seven hundred and fifty dollars ($3,750) per family.

(9) An insurer offering a PPO benefit plan may limit coverage for annual physicals and health screenings performed for preventative purposes to those services provided on an in-network basis, except that services provided in connection with mandated benefits must be available on both an in-network and out-of-network basis. An insurer shall provide coverage on both an in-network and out-of-network basis for all other covered services.

(10) PPO benefit plans shall give enrollees the option to choose in-network covered services or out-of-network covered services each time those covered services are authorized, obtained, or rendered; and shall not require enrollees to obtain insurer approval to exercise that option.

(11) An insurer offering a PPO benefit plan shall not impose different medical management requirements, including utilization review criteria or prior approval requirements, for out-of-network covered services than are imposed on in-network covered services. Those medical management requirements shall not restrict enrollees' abilities to seek covered services on out-of-network bases.

History Note: *Authority G.S. 58-2-40; 58-50-56;*
Temporary Adoption Eff. January 1, 1998;
Eff. ~~August 1, 1998.~~ August 1, 1998;
Readopted Eff. March 1, 2020.