

**Government of Puerto Rico  
OFFICE OF THE COMMISSIONER OF INSURANCE  
Guaynabo, Puerto Rico**

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DEPARTMENT OF STATE  
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Approved: Hon. Kenneth D. McClintock  
Secretary of State  
**(SIGNED)**  
By: Eduardo Arosemena-Muñoz  
Assistant Secretary for Services]

**AMENDMENT TO RULE 73, REGULATION NO. 6559**

**STANDARDS FOR THE REGULATION OF TIMELY PAYMENT OF CLAIMS TO  
HEALTH CARE PROVIDERS**

**Government of Puerto Rico**  
**OFFICE OF THE COMMISSIONER OF INSURANCE**  
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**TABLE OF CONTENTS**

**AMENDMENT TO RULE 73, REGULATION NO. 6559**

**STANDARDS FOR THE REGULATION OF TIMELY PAYMENT OF CLAIMS TO  
HEALTH CARE PROVIDERS**

SECTION 1. - LEGAL BASIS.....	1
SECTION 2. - PURPOSE AND SCOPE .....	1
SECTION 3. - DEFINITIONS .....	1
SECTION 4. - ELEMENTS OF A CLEAN CLAIM.....	3
SECTION 5. - TERMS FOR FILING AND PAYMENT OF CLEAN CLAIMS.....	4
SECTION 6. - REIMBURSEMENT AND CHALLENGE OF REIMBURSEMENT .....	6
SECTION 7. - DISCLOSURE OF CLAIM-PROCESSING PROCEDURES.....	7
SECTION 8. - DELEGATION OF CLAIMS PAYMENT .....	7
SECTION 9. FAILURE TO MEET CLAIMS PAYMENT PERIOD.....	8
SECTION 10. - DATE OF CLAIM RECEIPT .....	8
SECTION 11. - TERMS OF CONTRACTS.....	9
SECTION 12. - GRIEVANCES AND REQUESTS FOR INVESTIGATION.....	9
SECTION 13. - UNFAIR COMPETITION AND FRAUD .....	10
SECTION 14. - PENALTIES.....	10
SECTION 15. - POWERS OF THE COMMISSIONER .....	10
SECTION 16. - AUTHORITY TO MODIFY APPENDIXES .....	10
SECTION 17. - SEVERABILITY .....	10
SECTION 18 - EFFECTIVE DATE .....	10
APPENDIX I .....	11
APPENDIX II .....	13
APPENDIX III.....	15
APPENDIX IV .....	17



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**SECTION 1. - LEGAL BASIS**

The Office of the Puerto Rico Commissioner of Insurance adopts this amendment to Rule 73, Regulation 6559 of the Regulations of the Puerto Rico Insurance Code, hereinafter the Rule, pursuant to the authority vested in the Office under Sections 2.030 and 30.080 of Public Law 77, enacted on June 19, 1957, as amended, known as the Puerto Rico Insurance Code, as well as the provisions of Public Law No. 150, enacted on July 27, 2011, and Public Law 170, enacted on August 12, 1988, as amended, known as the Puerto Rico Uniform Administrative Procedures Act.

**SECTION 2. - PURPOSE AND SCOPE**

This Rule is adopted for the purpose of establishing the necessary standards to ensure and regulate the timely payment of claims filed by participating providers for health care services provided to enrollees of Insurers or health services organizations.

This Rule shall be applicable to all claims filed by participating providers to Insurers or health services organizations, in writing or in electronic format, for health care services provided to enrollees of such Insurers and health services organizations.

This Rule shall not be applicable to claims for payment for services provided by participating providers that are filed after the term of ninety (90) calendar days as provided for in Section 30.030 of the Puerto Rico Insurance Code, unless a longer term shall have been established by agreement between the parties, nor will it be applicable to claims specified in Section 30.060 of said Code.

**SECTION 3. - DEFINITIONS**

The following terms and phrases shall have the meanings stated below:

- A. "Insurer" means an entity engaged in contracting insurance in Puerto Rico as defined in Sections 1,030 and 3.010 of the Puerto Rico Insurance Code.
- B. "CMS" means "Centers for Medicaid and Medicare Services" of the United States Department of Health.
- C. "Code" means the Puerto Rico Insurance Code.
- D. "Condition code" means the code used by CMS to identify conditions that could affect the processing of the claim.
- E. "Diagnosis code" means the code number known as ICD-9-CM.

- F. "Occurrence span code" means the code used by CMS to define a specific event related to the billing period.
- G. "Commissioner" means the Puerto Rico Commissioner of Insurance.
- H. "Payment-processing entity" means the entity to which the Insurer or Health Management Organization has delegated the function of receiving, evaluating and making the payment for the claim.
- I. "Provider claim-processing entity" means the entity to which the Participating Provider has delegated the function of processing claims.
- J. "HIPAA" means the federal law known as the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996.
- K. "Service line" means a health care service provided within the same claim.
- L. "Form 1450" means the latest edition of the Health Care Plan claim form maintained by CMS to be used by institutional Participating Providers or any other form that such entity may approve from time to time.
- M. "Form 1500" means the latest edition of the Health Care Plan claim form maintained by CMS to be used by non-institutional Participating Providers or any other form that such entity may approve from time to time.
- N. "Form J515" means the most recent edition of the claim form for dental insurance approved by the American Dental Association for use by dentists or any other form which said entity may approve from time to time.
- O. "Health Services Organization" means any person who offers or contracts to provide health care plans to one or more enrollees as defined in Chapter 19 of the Code.
- P. "Person" means a natural or legal person.
- Q. "Primary Plan" means a Health Care Plan for which benefits are determined without taking into account the existence of any other Health Care Plan.
- R. "Secondary Plan" means a Health Care Plan for which benefits are determined after applying and deducting benefits paid by the Primary Plan.
- S. "Health Care Plan" means any "Health Care Plan" as defined in Section 19.020 of the Code; any disability or health care insurance, or any health care plan doing business in Puerto Rico, even though [such plan] operates as an association that includes medical benefits, irrespective of the law of the Commonwealth of Puerto Rico under which it may be organized or authorized to do business, except the agencies or public corporations of the Commonwealth of Puerto Rico.
- T. "Claim" means health care service furnished by a Participating Provider to a patient on a single date.
- U. "Participating Provider" means any physician, hospital, primary service center, diagnosis and treatment center, dentist, laboratory, pharmacy, pre-hospitalization emergency medical service or any other person authorized to provide health care services in Puerto Rico, who under contract with an Insurer or a health services organization may provide health care services to enrollees or beneficiaries of a Health Care Plan.
- V. "Clean Claim" means any claim that complies with the requirements established in Chapter 30 of the Code and this Rule.

W. "Not Clean Claim" means any claim that is not processable for payment as established in Chapter 30 of the Code and this Rule.

## **SECTION 4. ELEMENTS OF A CLEAN CLAIM**

### **SUBSECTION 1. - REQUIRED CLEAN CLAIM ELEMENTS**

The Participating Provider shall submit a clean claim for payment by providing the data elements required in Form 1500 and Form 1450 as established in Appendixes I and II of this Rule, as well as required data elements, if applicable, as provided in Appendix III of this Rule. All Participating Providers shall also file such additional attachments that they may have been advised as being necessary under Subsection 4 of this Section.

### **SUBSECTION 2. REQUIRED DATA ELEMENTS APPLICABLE FOR INSTITUTIONAL OR NON-INSTITUTIONAL PARTICIPATING PROVIDERS.**

Unless otherwise agreed by contract and insofar as HIPAA provisions regarding universal transactions and codes are not contravened, the data elements described in Appendixes I and II of this Rule shall be necessary for Claims filed by non-institutional Participating Providers and institutional Participating Providers, respectively.

### **SUBSECTION 3. NECESSARY DATA ELEMENTS, IF APPLICABLE**

Unless otherwise agreed by contract and insofar as HIPAA provisions regarding universal transactions and code sets are not contravened, the data elements described in Appendix III of this Rule shall be necessary in claims filed by Participating Providers if there are circumstances that make such data elements applicable to the specific claim being filed. Applicability of a given data element in Appendix III of this Rule shall be determined according to the situation in which the claim arose.

### **SUBSECTION 4. - ATTACHMENTS**

In addition to the data elements required by the provisions of Subsection 1 of this Section, CMS has developed several manuals that identify various attachments that are required of the different Participating Providers for specific services. An Insurer or health services organization may use the corresponding Medicare standards currently in effect for the attachments in order to adequately process claims for certain kinds of services.

An Insurer or health services organization may only require as an attachment information appearing or that may be in the process of being included in the medical or billing record of the patient maintained by the Participating Provider. Before requiring any attachment that is additional to those already required by contract, whether required by federal or local law or regulation, or by agreement between the parties, the Insurer or health services organization shall notify in writing all Participating Providers concerned to the effect that such additional attachments are necessary. The notice shall specifically identify the required attachments and shall be received by the Participating Provider at least sixty (60) calendar days before such attachment will be required to consider that a claim is a clean claim. If any different term has been provided by federal or local law or regulation or by agreement between the parties, notice required herein shall be effected according to said term.

Claims submitted during the sixty (60) calendar day period, or during any other period established by federal or local law or regulation or by agreement between the parties, after receipt of the disclosure notice, shall not be required to include the attachment identified in said disclosure notice in order to be considered a clean claim.

#### SUBSECTION 5. - ADDITIONAL ELEMENTS OF A CLEAN CLAIM

An Insurer or health services organization may not require elements that are additional to the data elements and attachments established in Appendixes I, II, and III of this Rule unless required to do so by CMS or federal or local law or regulation or by agreement between the parties.

#### SUBSECTION 6. - COORDINATION OF BENEFITS

If the Claim submitted requires coordination of benefits, the amount paid by the Primary Plan shall be considered a required element for a clean claim for the purposes of processing the Claim by the Secondary Plan and field 29 of Form 1500 or field 54 of Form 1450 shall be completed pursuant to Appendix III of this Rule, paragraphs (D) and (K), and a copy of the explanation of payment by the Primary Plan shall also be attached.

If an Insurer or health services organization has in the first instance paid for a service furnished and later becomes aware of the fact that the insured has a Primary Plan at the time such services were furnished, said Insurer or health services organization may recover the amount paid from said Primary Plan.

#### SUBSECTION 7. - FORMAT OF CLAIM ELEMENTS

The elements that are required for considering a Claim to be a clean claim as established in this Section, shall be complete, legible, and accurate. Claims that are transmitted or received electronically shall comply with the standards set forth in the HIPAA Electronic Health Care Transactions and Code Sets pursuant to HIPAA.

#### SUBSECTION 8. - THE CONTRACT

The Insurer or health services organization shall set forth in the contract entered into with Participating Providers the specific attachments that may be required to consider a Claim a clean claim. The Insurer or health services organization may only require attachments other than those specified in the contract if such are required by federal or local law or regulation or by agreement between the parties. In such cases, the Insurer or health services organization shall comply with the notification requirements in Subsection 4 of Section 4 of this Rule.

When the Insurer or health services organization acts as administrator of a health care plan, the Insurer or health services organization may require additional information when such information is required by the health care plan offered by an employer to its employees. In such case, the notice required under Subsection 4 of Section 4 of this Rule shall be received by the Participating Provider in no less than fifteen (15) calendar days.

#### SUBSECTION 9. - CLAIMS OF PARTICIPATING PROVIDERS WHO ARE DENTISTS

Claims filed by Participating Providers who are dentists using Form J515 shall be considered clean claims provided such claims comply with paragraph (A) of Section 5 of this Rule.

### SECTION 5 - TERMS FOR FILING AND PAYMENT OF CLEAN CLAIMS

- A. The Participating Provider shall submit Claims for payment for services provided within ninety (90) calendar days of having provided such services except when a longer term has been established by agreement between the parties. Receiving a

Claim beyond the ninety (90) day term or the term established by agreement between the parties shall imply that the provisions of this rule and Chapter 30 of the Code shall not be applicable.

The term for submitting claims for institutional Participating Providers shall begin from the date of discharge of the patient. In all other cases, it shall be counted from the date in which the service was furnished.

When the Insurer or health services organization is a Secondary Plan, the ninety (90) calendar-day term (or such other longer term established by agreement between the parties) shall be counted from the date on which the Participating Provider received the determination from the Primary Plan.

B. The thirty (30) calendar-day term (or such shorter term established by agreement between the parties) for payment of a claim shall begin on receipt of the claim from the Participating Provider at the address indicated by the Insurer or health services organization, pursuant to Section 7 of this Rule, regardless of whether it is the address of the Insurer, the health services organization or the entity designated by the Insurer or health services organization to process payment. For the purposes of determining compliance with the term for payment of claims, payment shall be considered to have been made on the date of:

- (1) the postmark, if a claim payment is delivered by regular mail or certified mail, return receipt requested;
- (2) electronic transmission, if a claim payment is made electronically;
- (3) delivery of the claim payment by a commercial carrier or
- (4) receipt by the Participating Provider, if a claim payment is made by messenger or in person.

C. After receiving a claim the Insurer or health services organization shall:

- (1) pay the clean claim in full during the term provided in paragraph (B) of this Section or as provided in the contract with the Participating Provider, if the term is shorter;
- (2) object in writing or electronically, during a period of thirty (30) calendar days, counted from the date of receipt of the claim, clearly indicating the reasons for which the Insurer or health services organization considers that the claim is not a clean claim, whether because there is no payment liability or because the documents or data necessary for such payment were not included.

The Participating Provider shall respond to the objection within twenty (20) calendar days after receipt of notice from the Insurer or health services organization of such objection. Failure to respond to the objection shall be deemed an admission by the Participating Provider of the objections in the notice. Once the Participating Provider has provided the required information or documentation, the Insurer or health services organization shall proceed to pay the claim within thirty (30) calendar days from the receipt of the information or documentation.

It is nevertheless further provided that an erroneous objection to a claim

made by the Insurer or health services organization shall not interrupt the thirty (30) calendar-day term for payment, and the Insurer or health services organization shall proceed to pay the amount claimed plus the corresponding interest for any term in excess of said thirty (30) days, as provided in Section 9 of this Rule.

- (3) **pay, within** the term of thirty (30) calendar days, the portion of the Claim that is processable for payment and object to the remainder of the claim, in writing or electronically, within the term of thirty (30) calendar days, counted from the date of receipt of the claim, when it is determined that such remainder is not a clean claim, whether because there is no payment liability or because the documentation or information necessary for processing payment was not submitted. In such cases, the provisions of paragraph (2) above shall be followed.

In the case of claims to which the Insurer or health services organization objects to a service line that depends on others for determining the amount of payment, the Insurer or health services organization may object to such service lines.

- D. It shall not be deemed that the thirty (30) calendar-day term for payment of clean claims abrogates any shorter term established by contractual agreement between the parties.

## **SECTION 6. REIMBURSEMENT AND CHALLENGE OF REIMBURSEMENT**

- A. Pursuant to Section 30.040 of the Code, the Insurer or health services organization shall be allowed a period of up to six (6) years, counted from the moment payment is made, to request reimbursement by the Participating Provider of any claim paid that may be determined not to be a clean claim within such period, for the following reasons:

- (1) The claim is for a health care service not covered by the Health Care Plan; or
- (2) The claim is for a service that is covered but was not furnished; or
- (3) The claim is for a costlier or more complex service than that which was actually furnished; or
- (4) There was an error in the payment made regarding the amount and/or payee; or
- (5) The same service was billed more than once.

For the purposes of calculating the aforementioned six (6) years, payment shall be deemed to have been made on the date that the Insurer or health services organization shall have issued such payment.

Once the Insurer or health services organization determines that a claim that was not a clean claim was paid, the Insurer or health services organization may request the corresponding reimbursement in writing, including the grounds for such request. The written notice shall include a list of the claims that are not clean claims that were paid and the amounts to be recovered.

The Participating Provider shall be allowed a term of ninety (90) calendar days in which to object to the reimbursement or effect the requested payment. The reimbursement

may be made through any means, including a chargeback to the Participating Provider, or through any means agreed to contractually between the parties. Except as otherwise contractually agreed, if the Insurer or health services organization should decide to effect a chargeback, the written notice shall also include a statement that the Insurer or health services organization will effect the chargeback, unless the Participating Provider contacts the Insurer or health services organization to make the arrangements for reimbursement through an alternative method. No provision herein shall abrogate or substitute any existing or future contractual relationship that allows for alternative recovery methods in the case of payment to the Participating Provider of claims that are not clean claims. The Participating Provider who objects to the request for reimbursement shall exhaust the internal procedures established by the Insurer or health services organization before addressing any objection to the Office of the Commissioner of Insurance by requesting an investigation. The party aggrieved by the finding of the Commissioner may have recourse to adjudicatory administrative proceedings. The party aggrieved in said administrative proceeding may subsequently request judicial review by the Commonwealth of Puerto Rico Circuit Court of Appeals, if such party so desires.

## **SECTION 7. DISCLOSURE OF CLAIM-PROCESSING PROCEDURES**

- A. All Insurers and health services organizations shall disclose the following information to Participating Providers:
- (1) the address, including a street address, where claims are to be sent for processing;
  - (2) the telephone number that Participating Providers may call to ask questions and express concerns;
  - (3) any payment-processing entity to which the Insurer or health services organization has delegated claim payment functions, if any; along with its address, including the street address and telephone number, and
  - (4) the address, including the street address and telephone number of any branch authorized to receive claims.
- B. The Insurer or health services organization shall notify any change of address or change in the delegation of claim payment functions by mailing written notice to each Participating Provider with which the Insurer or health services organization has a contract, no fewer than sixty (60) calendar days in advance, including any change of address for filing claims or any change in the delegation of claim payment functions.
- C. Any Insurer or health services organization that has not sent timely notice to Participating Providers pursuant to the provisions of this Section may not deny any claim on the grounds that the Participating Provider did not submit a clean claim during the term established in Section 5 of this Rule.

## **SECTION 8. DELEGATION OF CLAIMS PAYMENT**

No agreement or stipulation between an Insurer or health services organization and a payment-processing entity in which claim-payment functions are delegated shall be construed as exempting the Insurer or health services organization of the responsibility of

complying with the provisions of this Rule and Chapter 30 of the Code.

#### **SECTION 9. FAILURE TO MEET CLAIMS PAYMENT PERIOD**

The Insurer or health services organization who fails to meet the claims payment period pursuant to Section 5 of this Rule or such period that may have been agreed to between the parties contractually, if such term were shorter, shall pay interest from the day after the expiration of said term until the moment payment is issued, provided that such payment is sent to the Participating Provider within the next three (3) business days from having been issued. If payment is not sent in such term, interest shall be calculated until the date the provider receives the corresponding payment.

Interest shall be calculated based on the prevailing legal interest rate at the time payment should have been made, as set by the Financial Institutions Commissioner. Likewise, claims that may have been erroneously objected to as not being clean claims and have not been paid during the term provided in Section 5 of this Rule or in the contract, if such term were shorter, shall accrue interest as provided in this Section.

#### **SECTION 10. DATE OF CLAIM RECEIPT**

- A. Participating Providers and Insurers or health services organizations may agree contractually on the procedure for establishing the date of claim receipt.
- B. If a Participating Provider and Insurer or health services organization does not establish contractually the date of claim receipt, said date shall be established by using one of the following procedures:
  - (1) submitting the claim by regular mail, certified return receipt requested, or by overnight delivery service, and maintain a log that complies with paragraph (D) of this Section in which each claim included in the submission is identified. A copy of the log shall be included with the claim;
  - (2) submitting the claim electronically and maintaining proof of the electronically submitted claim;
  - (3) hand-delivering the claim, in which case a log identifying each claim submitted should be included. Said log shall comply with the requirements of paragraph (D) of this Section. The provider shall keep a copy of the signed receipt, which shall show the delivery date.
- C. The date of claim receipt shall be determined as follows for each of the procedures established in paragraph B above:
  - (1) If the claim is submitted by regular mail, the claim shall be presumed to have been received on the third business day after the date the claim was sent along with the log. If the claim is sent through an overnight delivery service or by certified mail, return receipt requested, it shall be presumed that the claim was received on the date the delivery receipt was signed.
  - (2) If the claim is submitted electronically, the claim shall be presumed to have been received on the date of the electronic receipt confirmation by the Insurer or health services organization or by the payment processing entity. If the Insurer, health services organization or payment processing entity does not provide receipt confirmation of the claim within twenty-four (24) hours, the Participating Provider or the claim-processing entity of the provider shall

send the Insurer, health services organization or payment processing entity a confirmation of the claim delivery. The Participating Provider or the provider's claim-processing entity shall verify that the claim that was submitted included the correct identification of the entity that is responsible for making payment.

(3) If the claim is hand-delivered, it shall be presumed that the claim was received on the date of the signature of the delivery receipt.

D. The claim delivery log to be prepared by the Participating Providers shall include the following information: the Participating Provider's name; the provider's address; the Participating Provider's telephone number; the Participating Provider's Employer Identification Number; the Insurer or health services organization's name; the delivery service's name; the designated address; the date of sending or hand delivery; the enrollee's name; the enrollee's ID number; the patient's name; the service/occurrence date(s); total charges, and method of delivery.

E. A sample of the claim delivery log to be prepared by Participating Providers is included in Appendix IV to this Rule.

## **SECTION 11. - TERMS OF CONTRACTS**

Contracts between Insurers and health services organizations and Participating Providers shall not include terms that:

- (1) extend the statutory or regulatory time frames for payment of clean claims; or
- (2) reduce the statutory or regulatory time frames for submission of a clean claim;  
or
- (3) waive the Participating Provider's right to charge interest on any amount of a clean claim that is not paid within the term provided for such payment, pursuant to Section 30.070 of the Code.

## **SECTION 12. GRIEVANCES AND REQUESTS FOR INVESTIGATION**

All Insurers and health services organizations shall establish internal administrative procedures to address all grievances that may arise under the provisions of Chapter 30 of the Code. The internal grievance-resolution administrative procedure shall include the designation of a grievance committee, constituted by no fewer than three (3) members appointed at the discretion of the Insurer or the health services organization. Grievances shall be resolved by the grievance committee in a term of no more than thirty (30) calendar days.

Participating Providers shall exhaust the internal administrative procedures of the Insurer or health services organization, before the Participating Providers may be allowed to request the intervention of the Office of the Commissioner of Insurance. Nevertheless, the internal administrative procedure used by the Insurer or health services organization to address a grievance submitted by the Participating Provider shall not be used to delay compliance with the applicable terms established in Chapter 30 of the Code and this Rule. Any Participating Provider who has grounds for believing that an Insurer or health services organization that is subject to the provisions of this Rule has acted in violation of the standards established by this Rule, after having exhausted the internal administrative procedures of the Insurer or health services organization, may request that the Office of the Commissioner of Insurance carry out an investigation of the situation, and all actions and remedies provided by the Code, the Regulations and any other rule of the Office of the

Commissioner of Insurance shall be available to the Participating Provider. The actions and remedies provided by the Code, the Regulations and Public Law No. 170, *supra*, shall be available to the party aggrieved by the decision made by the Office of the Commissioner of Insurance.

### **SECTION 13. UNFAIR COMPETITION AND FRAUD**

The provisions of this Rule shall not be construed to preempt other provisions of Chapter 27 of the Code that regulate the acts and business practices of the insurance industry that constitute unfair competition methods or misleading acts or practices.

### **SECTION 14. PENALTIES**

Any violations of the provisions of this Rule shall be subject to the penalties provided for in Chapter 27 of the Code.

### **SECTION 15. POWERS OF THE COMMISSIONER**

The Commissioner shall have the power and authority as provided in Section 2.030 and Section 30.080 of the Code to examine and investigate all activities of the regulated entities and any other person, regarding timely payment of health care claims and uniform billing, subject to the provisions of this Rule and the Code for industry oversight purposes.

### **SECTION 16. AUTHORITY TO MODIFY APPENDIXES**

The fields defined in the Appendixes to this Rule for forms 1500 and 1450 shall be subject to such modification as may arise from the approval of the rule regarding HIPAA transactions and code sets or any other modification or amendment that may arise from any other law or regulation. The Office of the Commissioner of Insurance shall provide notice of said modifications to all Insurers and health services organizations in a ruling letter, and these shall in turn provide notice to Participating Providers.

### **SECTION 17. SEVERABILITY**

If any word, sentence, paragraph, section, or part of this Rule is found to be null or void by court of competent jurisdiction, the order issued by such court shall not affect nor invalidate the remaining provisions of this Rule and the effect of such order shall be limited to said word, sentence, paragraph, section, or part that shall have been so declared null and void.

### **SECTION 18. EFFECTIVE DATE**

The provisions of this Rule shall enter into effect thirty (30) days after filing with the Department of State of Puerto Rico, according to the provisions of Public Law No. 170, *supra*.

### **SIGNED**

RAMÓN L. CRUZ-COLÓN  
COMMISSIONER OF INSURANCE

Date of Approval: May 9, 2012

Date of Filing at the State Department:

Date of Filing at the Legislative Library:

## APPENDIX I

ESSENTIAL DATA ELEMENTS APPLICABLE TO  
NON-INSTITUTIONAL PARTICIPATING PROVIDERSForm 1500

- (A) "Insured's ID number" (field 1a)
- (B) "patient's name" (field 2)
- (C) "patient's date of birth and gender" (field 3)
- (D) "insured's name" (field 4)
- (E) "patient's address (street or PO Box, city, zip code)" (field 5)
- (F) "patient relationship to insured" (field 6)
- (G) "if the patient's condition is related to employment, an auto accident or other accident" (field 10)
- (H) "insured's policy group or FECA number" (field 11);
- (I) "name of the Insurance plan or program" (field 11c);
- (J) "is there another health benefit plan" (field 11d) – If there is another health benefit plan in effect:
  - (a) the data elements specified in paragraph (A) of Appendix III of this Rule are required unless the Participating Provider submits to the Insurance plan or program, along with the claim, a document signed during the last six (6) months by the patient or authorized person stating that there is no other health care benefit plan,
  - (b) the data element specified in paragraph (A) of Appendix III of this Rule will be required when a claim is filed with an Insurance plan or program that is a Secondary Plan,
  - (c) a copy of the explanation of the payment made by the Primary Plan must also be enclosed.
- (K) "patient's or authorized person's signature or a note to the effect that the signature is held in the records of the Participating Provider" (field 12);
- (L) "signature of the insured or representative of the minor or disabled person or a note to the effect that the signature is held in the records of the Participating Provider" (field 13);
- (M) "date of current illness, injury or pregnancy" (field 14);
- (N) "first date on which the illness or similar illness was diagnosed" (field 15);

- (O) "diagnostic codes or nature of illness or injury" (field 21);
- (P) "date(s) of service" (field 24A);
- (Q) "code of place of service" (field 24B);
- (R) "code of type of service" (field 24C);
- (S) "code of the procedure/modifier" (field 24D);
- (T) "diagnostic code of the specific service (diagnosis pointer)" (field 24E);
- (U) "detailed service charges" (field 24F);
- (V) "number of days or units" (field 24G);
- (W) "federal tax ID number of the Participating Provider " (field 25);
- (X) "total charge" (field 28);
- (Y) "signature of the Participating Provider or a note to the effect that the signature is held in the records of the Insurance plan or program" (field 31);
- (Z) "name and address of service facility (if not the home or office)" (field 32);
- (AA) "name and address of the Billing Provider (field 33).

**OPTIONAL DATA ELEMENTS APPLICABLE TO NON-INSTITUTIONAL  
PARTICIPATING PROVIDERS**

- (a) "insured's address (street or PO box, city, zip code)" (field 7);
- (b) "insured's date of birth and gender" (field 11a).

## APPENDIX II

REQUIRED DATA ELEMENTS APPLICABLE TO  
INSTITUTIONAL PARTICIPATING PROVIDERS**Form 1450**

- (A) "name, address and telephone number of the provider" (field 1);
- (B) " patient control number" (field 3);
- (C) "type of bill code" (field 4);
- (D) "federal tax number of the provider" (field 5);
- (E) "beginning and end dates of statement period" (field 6);
- (F) "name of the patient" (field 12);
- (G) "address of the patient" (field 13);
- (H) "date of birth of the patient" (field 14);
- (I) "gender of the patient" (field 15);
- (J) "marital status of the patient" (field 16);
- (K) "date of admission" (field 17);
- (L) "hour of admission" (field 18);
- (M) "type of admission" (for example, emergency, urgent, elective, newborn, field 19);
- (N) "source of admission code " (field 20);
- (O) "patient condition (status) at discharge code " (field 22);
- (P) "value and amount code" (fields 39-41);
- (Q) "revenue code " (field 42);
- (R) "description of revenue "(field 43);
- (S) " service units" (field 46);
- (T) " total charges" (field 47);
- (U) "name of the Insurance plan or program" (field 59);
- (V) " insured's name" (field 58);
- (W) "relationship or kinship of the patient with the insured" (field 59) Appendix II

- (X) " certificate number of the patient or insured, health claim number, patient or insured identification number " (field 60);
- (Y) " principal diagnosis code " (field 67);
- (Z) "attending physician identification number " (field 82);
- (AA) "signature of the Participating Provider's representative or note to the effect that the signature is held in the records of the Insurance plan or program" (field 85);  
and
- (BB)"date bill submitted" (field 86).

### APPENDIX III

#### NECESSARY DATA ELEMENTS, IF APPLICABLE

##### Form 1500

- (A) The following data elements will be applicable if the patient is covered under more than one Health Care Benefit Plan, unless the Participating Provider submits along with the claim a document signed during the past twelve (12) months by the patient or authorized individual stating that there is no other health care benefit plan:
- (i) "other insured's (or beneficiary 's) name" (field 9);
  - (ii) " other insured's (or beneficiary 's) policy or group number" (field 9a);
  - (iii) " other insured's (or beneficiary 's) date of birth" (field 9b);
  - (iv) "name of the plan of the other insured or beneficiary (employer, school, etc.)" (field 9c); and
  - (v) "name of the insurer or health services organization of the other insured or beneficiary)" (field 9d).
- (B) "name of the insured group" (field 11b), applicable if the health care benefit plan is a group plan;
- (C) "prior authorization number" (field 23), applicable when prior authorization is required;
- (D) "amount paid" (field 29), applicable if a payment has been made to the Participating Provider who filed a claim whether for a patient or an insured or on their behalf or for a primary Plan according to paragraph (L) of Appendix I of this Rule and as required in Subsection (6) of Section 4 of the Rule;
- (E) "balance due" (field 30), applicable if a payment has been made to the Participating Provider who filed a claim whether for a patient or an insured or on their behalf; Appendix III
- (F). " assignment accepted" (field 27), applicable when assignment has been accepted under Medicare;

##### Form 1450

- (G) "discharge hour" (field 21), applicable if the patient was hospitalized or admitted for observation as an out-patient;
- (H) "condition codes " (fields 24-30), applicable if the CMS manual for Form 1450 contains condition codes that are appropriate for the patient's condition;
- (I) "codes and dates of occurrence" (fields 31-36), applicable if the CMS manual for Form 1450 contains occurrence codes that are appropriate for the patient's condition;

- (J) "occurrence span code, beginning and end dates " (field 36), applicable if the CMS manual for Form 1450 contains occurrence span codes that are appropriate for the patient's condition;
- (K) "prior payments-payer and patient" (field 54), applicable if the patient or other payer or insured as well as a Primary Plan, as required in Subsection 6 of Section 4 of this Rule, has made a payment to the Participating Provider on behalf of the patient or insured;
- (L)"other diagnostic codes aside from principal diagnosis codes "(fields 68-75), applicable if there is any diagnosis aside from the principal diagnosis;
- (M) "procedure code method" (field 79), applicable if the CMS manual for Form 1450 indicates a procedure code method that is appropriate for the condition of the patient;
- (N) "principal procedure code " (field 80), applicable if the patient has been submitted to a surgical procedure, whether as a hospitalized patient or an out-patient;
- (O) "other Appendix III procedure codes" (field 81), applicable as an extension of paragraph (M) of this section if additional surgical procedures are performed; and
- (P) The following data elements will be applicable with regard to Medicare:
  - (i) "covered days" (field 7), applicable if Medicare is the Primary or Secondary Plan;
  - (ii) "not covered days" (1450, field 8), applicable if Medicare is the Primary or Secondary Plan;
  - (iii) "co-insurance days" (field 9), applicable if Medicare is the Primary or Secondary Plan;  
  
"lifetime reserve" (field 10), applicable if Medicare is the Primary or Secondary Plan if the patient is hospitalized; and
  - (y) "HCPCS/Rate" (field 44), applicable if Medicare is the Primary or Secondary Plan.

APPENDIX IV

CLAIM FILING LOG	
Name of the Participating Provider:	
Address of the Participating Provider:	
Telephone No. of the Participating Provider:	(_____)
Employer Identification Number of the Participating Provider:	
Name of the Insurer or Health Services Organization:	
Name of the Delivery Service:	
Designated Address:	
Date of mailing or hand delivery:	Page ____ of ____

Name of the Insured	Insured's ID Number	Patient's Name	Date(s) of Service/Occurrence	Total Charge	Method of Delivery