Public Protection Cabinet

Department of Insurance

Division of Health, Life Insurance and Managed Care

(Amendment)

806 KAR 17:370. Standardized health claim attachments.

RELATES TO: KRS 304.17A-005, 304.17A-607, 304.17A-700-304.17A-730, 304.17C-010, 304.17C-090, 304.39-010-304.39-340, [~~2008 Acts ch. 127, Part XII, secs 18-20~~], 42 C.F.R. 411.32, 441.203, 441.206, 441.207, 441.208, 441.250, 441.255, 441.256, 441.258

STATUTORY AUTHORITY: KRS 304.2-110(1), 304.17A-720(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) authorizes the commissioner [~~executive director~~] to promulgate reasonable administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code as defined in KRS 304.1-010. KRS 304.17A-720(1) requires the department to promulgate administrative regulations prescribing standardized health claim attachments to be used by insurers.[~~EO 2008-507, effective June 16, 2008, established the Department of Insurance and the Commissioner of Insurance as head of the department.~~] This administrative regulation establishes requirements for standardized health claim attachments and minimum requirements for routinely requested medical information health claim attachments.

Section 1. Definitions. (1) "Clean claim" is defined by [~~in~~] KRS 304.17A-700(3). (2) "Health benefit plan" is defined by [~~in~~] KRS 304.17A-005(22).

(3) "Health care provider" or "provider" is defined by [~~in~~] KRS 304.17A-700(9)[~~, as amended by 2008 Ky Acts ch. 127, Part XII, sec. 18~~].

(4)"Health claim attachments" is defined by [~~in~~] KRS 304.17A-700(10).

(5) "Insurer" is defined by [~~in~~] 304.17A-005(29) [~~304.17A-005(27)~~].

(6) "Limited health services benefit plan" is defined by KRS 304.17C-010(5).

(7) "Practitioner" means an individual licensed or certified to provide a health care service in Kentucky.

(8) "Reparation obligor" is defined by [~~in~~] KRS 304.39-020(13).

Section 2. Standardized Health Claim Attachments. If another payment source is identified by a provider, an insurer shall require the provider to include the following health claim attachments, as applicable, for a claim to qualify as a clean claim:

(1) An explanation of benefits statement or noncoverage notice from another payer;

(2) An electronic or paper-based Medicare remittance notice if the claim involved Medicare as a payer; and

(3) A record of all payments by a reparations obligor pursuant to KRS 304.39-010 to 304.39- 340.

1 Section 3. Routinely-requested Health Claim Attachments. An insurer offering a health
2 benefit plan or a limited health service benefit plan for dental only, may routinely request the
3 following health claim attachments in accordance with KRS 304.17A-706(2), as applicable:
4 (1) A certification of medical necessity;
5 (2) A complete medical record, or part of a medical record, including:
6 (a) Discharge summary:
7 1. Patient identification, including name, age, gender, and medical record number;
8 2. Name of attending practitioner;
9 3. Dates of admission and discharge;
10 4. Final diagnosis;
11 5. Reason for the admission or visit;
12 6. Medical history;
13 7. Significant findings during length of stay or visit;
14 8. Procedures and treatments;
15 9. Patient condition at discharge;
16 10. Discharge medications; and
17 11. Discharge instructions;
18 (b) Emergency department report:
19 1. Patient identification, including name, age, gender, and medical record number;

1 2. Date of service;

2 3. Attending practitioner;

3 4. Chief complaint and symptoms;

4 5. History of present illness and physical exam;

5 6. Diagnostic test findings;

6 7. Clinical impression and diagnosis;

7 8. Treatment plan;

8 9. Discharge instructions; and

9 10. Practitioner orders;

10 (c) History and physical:

11 1. Patient identification, including name, age, gender, and medical record number;

12 2. Chief complaint;

13 3. Details of present illness;

14 4. Relevant past, social and family histories;

15 5. Inventory by body system;

16 6. Summary of psychological needs;

17 7. Report of relevant physical exam;

18 8. Statement relating to the conclusions or impressions drawn from the admission history

19 and physical;

1 9. Statement relating to the course of action planned for this episode of care; and

2 10. Name of practitioner performing history and physical;

3 (d) Nurse's notes:

4 1. Patient identification, including name, age, gender, and medical record number;

5 2. Vital signs with graphics, if available;

6 3. Intake and output record, if applicable;

7 4. Medication administration records;

8 5. Date of nurse's notes;

9 6. Nurse assessment;

10 7. Nursing intervention;

11 8. Observation; and

12 9. Name of nurse;

13 (e) Operative report:

14 1. Patient identification, including name, age, gender, and medical record number;

15 2. Date of procedure;

16 3. Operating practitioner;

17 4. Pre- and post-operative diagnoses;

18 5. List of procedures performed;

19 6. Operative description including indications and findings;

1 7. Anesthesia used; and

2 8. Specimens collected;

3 (f) Progress notes:

4 1. Patient identification, including name, age, gender, and medical record number;

5 2. Discharge or treatment plan;

6 3. Practitioner orders;

7 4. Practitioner notes;

8 5. Attending practitioner name;

9 6. Results of tests and treatments;

10 7. Dates of notes; and

11 8. Chief complaint;

12 (g) Test results:

13 1. Patient identification, including name, age, gender, and medical record number;

14 2. Test findings, including date ordered and date competed; and

15 3. Ordering practitioner name;

16 (h) Practitioner orders or treatment plan, as applicable:

17 1. Patient identification, including name, age, gender, and medical record number;

18 2. Practitioner orders;

19 3. Ordering practitioner name; and

1 4. Order dates;

2 (i) Practitioner notes:

3 1. Patient identification, including name, age, gender, and medical record number;

4 2. Practitioner name;

5 3. Practitioner notes; and

6 4. Dates of notes;

7 (j) Consult notes and reports:

8 1. Patient identification, including name, age, gender, and medical record number;

9 2. Practitioner name;

10 3. Findings and recommendations including notes and reports; and

11 4. Dates of notes and reports;

12 (k) Anesthesia record:

13 1. Patient identification, including name, age, gender, and medical record number;

14 2. Administering practitioner name;

15 3. Start and stop anesthesia times;

16 4. Route of administration;

17 5. Dates;

18 6. Notes;

19 7. Patient vital signs; and

8. Drug administered;

(l) Therapy notes:

1. Patient identification, including name, age, gender, and medical record number;

2. Practitioner name;

3. Practitioner orders;

4. Treatment plan;

5. Number of treatments and dates;

6. Therapist's notes; and

7. Dates of notes;

(m) Office notes:

1. Patient identification, including name, age, gender, and medical record number;

2. Practitioner name;

3. Any notes generated for dates of service; and

4. Dates of notes;

(n) Dental records; and

(o) Pharmacy records;

(3) Certification and documentation as identified in 42 C.F.R. 441.203, 441.206, 441.207, 441.208, 441.250, 441.255, 441.256, and 441.258;

(4) Itemized bill; and

1 (5) Evidence of Medicare secondary payment pursuant to 42 C.F.R. 411.32.