11 NCAC 23F .0106 EMPLOYER, INSURANCE CARRIER, MANAGED CARE ORGANIZATION, OR AGENTS' RECEIPT OF MEDICAL BILLS FROM HEALTH CARE PROVIDERS

(a) Upon receipt of medical bills submitted in accordance with the rules in this Subchapter, a payer shall evaluate each bill's conformance with the criteria of a complete medical bill. A payer shall not return to the health care provider medical bills that are complete, unless the bill is a duplicate bill. Within 21 days of receipt of an incomplete medical bill, a payer or its agent shall either:

(1) Complete the bill by adding missing health care provider identification or demographic information already known to the payer; or

(2) Return the bill to the sender, in accordance with this Paragraph.

(b) The received date of an electronic medical bill is the date all of the contents of a complete electronic bill are successfully received by the claims payer.

(c) The payer may contact the health care provider to obtain the information necessary to make the bill complete. Any request by the payer or its agent for additional documentation to pay a medical bill shall:

(1) be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery;

(2) be specific to the bill or the bill's related episode of care;

(3) describe with specificity the clinical and other information to be included in the response;

(4) be relevant and necessary for the resolution of the bill;

(5) be for information that is contained in or is in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider; and

(6) indicate the reason for which the insurance carrier is requesting the information.

If the payer or its agent obtains the missing information and completes the bill to the point it can be adjudicated for payment, the payer shall document the name and telephone number of the person who supplied the information. Health care providers and payers, or their agents, shall maintain, in a reproducible format, documentation of communications related to medical bill processing.

(d) A payer shall not return a medical bill except as provided in this Rule. When returning an electronic medical bill, the payer shall identify the reason(s) for returning the bill by utilizing the appropriate Reason and Rejection Code identified in the standards identified in this Subchapter.

(e) The proper return of an incomplete medical bill in accordance with this section fulfills the obligation of the payer to provide to the health care provider or its agent information related to the incompleteness of the bill.

(f) Payers shall timely reject bills or request additional information needed to reasonably determine the amount payable as follows:

(1) For bills submitted electronically, the rejection of all or part of the bill shall be sent to the submitter within two days of receipt.

(2) If bills are submitted in a batch transmission, only the specific bills failing edits shall be rejected.

(g) If a payer has reason to challenge the coverage or amount of a specific line item on a bill, but has no reasonable basis for objections to the remainder of the bill, the uncontested portion shall be paid timely, as required in this Rule.

(i) Payment of all uncontested portions of a complete medical bill shall be made within 30 days of receipt of the original bill, or receipt of additional information requested by the payer allowed under the law. After 60 days an amount equal to 10 percent shall be added to an unpaid bill.

(j) A payer shall not return a medical bill except as provided in this Rule. When returning a medical bill, the payer shall also communicate the reason(s) for returning the bill.

History Note: *Authority G.S. 97-18(a); 97-26(g1); 97-80;*
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