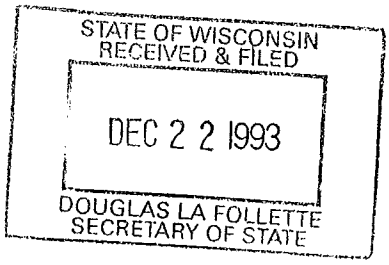
CR 93-184



STATE OF WISCONSIN)
)
OFFICE OF THE COMMISSIONER OF INSURANCE)

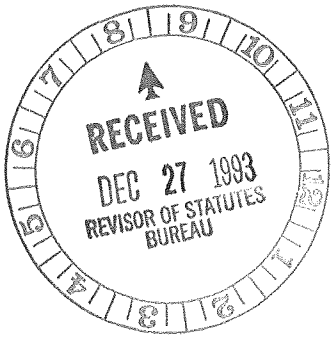
I, Randy Blumer, Deputy Commissioner of Insurance and custodian of the official records of this office, certify that the attached rule-making order affecting ss. Ins 3.65 and 3.651, Wis. Adm. Code, relating to standarized remittance advice and explanation of benefits formats for use by health insurers, was issued by this office on December 22, 1993.

I further certify that I have compared this copy with the original on file in this office and that it is a true copy of the whole of the original.

Dated at Madison, Wisconsin, this 21st day of December 1993.

Randy Blumer
Deputy Commissioner of Insurance

43302T-3



3-1-94

ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

REPEALING, RENUMBERING AND AMENDING, AMENDING,

REPEALING AND RECREATING, AND CREATING A RULE

To repeal Ins 3.651 (5) Note; to renumber Ins 3.651 (4) (a) 5. b and c and 8 to 11; to amend Ins 3.65 (6) (b), 3.651 (2) Note and (4) (a) 6 and 7; to repeal and recreate Ins 3.651 (3) and (5); and to create Ins 3.651 (4) (a) 8 (intro.), relating to standardized remittance advice and explanation of benefits formats for use by health insurers.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3) and 632.725 (2) (c), Stats.

Statutes interpreted: s. 632.725 (2) (c), Stats.

The office of the commissioner of insurance (OCI) is required by statute to promulgate administrative rules establishing a standardized explanation of benefits (EOB) format for health care insurance benefits that must be used by insurers providing health care coverage to Wisconsin residents on and after July 1, 1993. An emergency rule establishing the requirements took effect in June 1993, and the corresponding permanent rule took effect

September 1, 1993. That rule prescribed the requirements for both the EOB forms that insurers provide to their insureds and the remittance advice (RA) forms that insurers must furnish to health care providers with direct payments. It required insurers to conform both types of forms to a prescribed format by January 1, 1994.

An emergency rule revising that rule was published on October 1, 1993. It makes certain technical changes in the required formats which were requested by representatives of health insurers. This rule corresponds to the emergency rule and will make its provisions permanent.

The section governing the RAs prescribes the format as an appendix to the rule, but permits an insurer to vary the location of certain data elements for clarity, to eliminate data elements that do not apply to the claims paid, and to furnish providers with additional information. This section also eliminates the requirement that an insured's address be included on the form.

The emergency rule retains the January 1, 1994, applicability date for the RA format, except that an insurer that currently has a contract with a provider governing the RA form may continue to use the current form until the first contract renewal date after January 1, 1994. Insurers that do not have contracts governing the form and content of RAs must use the standardized format prescribed in the emergency rule and this rule beginning on January 1, 1994.

Insurers with less than $50,000 in annual health insurance premiums written in Wisconsin need not use the exact format prescribed in the appendix, but must furnish providers with an RA form that includes all the prescribed data elements.

This rule does not prescribe a format for EOB forms, but makes certain minor technical revisions in the list of required data elements and

permits more flexibility than does the current rule. Insurers must comply with the emergency rule by January 1, 1994.

OCI intends to continue working with health insurers to develop a standardized EOB format for use beginning January 1, 1995.

This rule specifies that OCI will update its list of claim adjustment reason codes, required for use with both the RA and EOB forms, twice a year. Insurers will be required to use the updated codes by the first day of the 4th month after receiving notice that they are available.

The rule also corrects an error in a related section of the administrative code.

SECTION 1. Ins 3.65 (6) (b) is amended to read:

Ins 3.65 (6) (b) Filing claims. A health care provider may file a claim with an insurer using either a paper form or electronic transmission. If a health care provider does not file a claim on behalf of a patient, the health care provider shall provide the patient with the same form that would have been used if the ~~insurer~~ provider had filed a claim on behalf of the patient.

SECTION 1m. Ins 3.651 **Note** [following sub. (2)] is amended to delete the reference to "subsection (2)" and to substitute "subsections (2), (3) (b) 4. i, (4) (a) 5. f and (5)."

SECTION 2. Ins 3.651 (3) is repealed and recreated to read:

Ins 3.651 (3) REMITTANCE ADVICE TO HEALTH CARE PROVIDERS. (a) Use of remittance advice form required; exception. 1. With each payment to a health care provider, an insurer shall provide a remittance advice form conforming to the format specified in Appendix A, except as provided in subd. 2 and par. (d).

2. The remittance advice form of an insurer with less than $50,000 in annual premiums for health insurance sold in this state, as reported in its

most recent annual statement, is not required to conform to the format specified in Appendix A but, with each payment to a health care provider, the insurer shall provide a remittance advice form which includes all of the applicable information specified in par. (b).

(b) Information required. The remittance advice form shall include, at a minimum, all of the following information:

1. The insurer's name and address and the telephone number of a section of the insurer designated to handle questions and appeals from health care providers.

2. The insured's name and policy number, certificate number or both.

3. The last name followed by the first name and middle initial of each patient for whom the claim is being paid, the patient identification number and the patient account number, if it has been supplied by the health care provider.

4. For each claim, all of the following on a single line:

a. The date or dates the service was provided or procedure performed.

b. The CPT-4, HCPCS or CDT-1 code.

c. The amount charged by the health care provider.

d. The amount allowed by the insurer.

e. The deductible amount.

f. The copayment amount.

g. The coinsurance amount.

h. The amount of the contractual discount.

i. Each claim adjustment reason code, unless the claim is adjusted solely because of a deductible, copayment or coinsurance or a combination of any of them.

j. The amount paid by the insurer toward the charge.

(c) Grouping of claims required. 1. If an insurer includes claims for more than one policyholder or certificate holder on the same remittance advice form, all claims for the same policyholder or certificate holder shall be grouped together.

2. If an insurer includes claims for more than one patient on the same remittance advice form, all claims for the same patient shall be grouped together.

(d) Format; exceptions. Notwithstanding par. (a) 1 and Appendix A:

1. An insurer may print its remittance advice form in either horizontal or vertical format.

2. A remittance advice form need not include a column for any item specified in par. (b) 4 which is not applicable, but the order of the columns that are included may not vary from the order shown in Appendix A, except as provided in subd. 3.

3. A remittance advice form may provide additional information about claims by including one or more columns not shown in Appendix A immediately before the column designated for the claim adjustment reason code.

4. An insurer may alter the wording of a column heading shown in Appendix A provided the meaning remains the same.

5. If necessary for clarity when claims for more than one insured or more than one patient are included on the same form, an insurer shall vary the location of the information specified in par. (b) 2 and 3 to ensure that it appears with the claim information to which it applies.

(e) An insurer shall send the remittance advice form to the payee designated on the claim form.

SECTION 3. Ins 3.651 (4) (a) 5. b and c are renumbered Ins 3.651 (4) (a) 5. c and b.

SECTION 4. Ins 3.651 (4) (a) 6 and 7 are amended to read:

Ins 3.651 (4) (a) 6. ~~Immediately after each line containing the information required under subd. 5.~~ a A general description of ~~the~~ each procedure performed or service provided.

7. ~~Immediately after the information required under subd. 6.~~ a A narrative explanation of each claim adjustment reason code. An insurer may provide information in addition to the narrative accompanying the code on form OCI 17-007.

SECTION 5. Ins 3.651 (4) (a) 8 (intro.) is created to read:

Ins 3.651 (4) (a) 8 (intro.) Any of the following that apply:

SECTION 6. Ins 3.651 (4) (a) 8 to 11 are renumbered Ins 3.651 (4) (a) 8. a to d.

SECTION 7. Ins 3.651 (5) is repealed and recreated to read:

Ins 3.651 (5) CLAIM ADJUSTMENT REASON CODES; USE. The office shall prepare updated claim adjustment reason code forms at least semiannually and shall notify insurers of their availability. In preparing remittance advice and explanation of benefits forms, an insurer shall use the claim adjustment reason codes provided by the office of the commissioner of insurance by no later than the first day of the 4th month beginning after being notified that an updated list of codes is available.

SECTION 8. Ins 3.651 **Note** [following sub. (5)] is repealed.

SECTION 9. Ins 3.651 Appendix A is created to read:

;

APPENDIX A

REMITTANCE ADVICE

INSURER
NAME & ADDRESS
CONTACT #

PAYEE/PROVIDER
NAME & ADDRESS

INSURED NAME & ADDRESS

INSURED ID #

PATIENT NAME

PATIENT ID #

PATIENT ACCT #

SERVICE DATE(S)	SERVICE CODE	CHARGED AMOUNT	ALLOWED AMOUNT	DEDUCT-IBLE	COPAY	COINSUR-ANCE	DISCOUNT	ANSI CODE	PAID

812R7
12/22/93

OCI 26-061 (C 09/93)

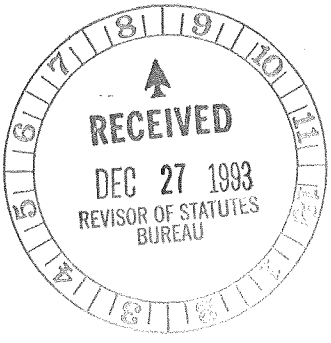
SECTION 10. COMPLIANCE WITH PREVIOUS RULES; APPLICABILITY OF EMERGENCY RULE. (1) Sections Ins 3.651 (3) and (4) (a), as affected by this rule, apply on and after the effective date of this rule, except as provided in subsection (2).

(2) If, on the effective date of this rule, an insurer has a contract with a health care provider that governs the form and content of remittance advice forms, section Ins 3.651 (3), as affected by this rule, first applies to the insurer on the date the contract is renewed, but no later than December 31, 1994.

SECTION 11. EFFECTIVE DATE. This rule will take effect on the first day of the month beginning after publication, as provided in s. 227.22 (2) (intro.), Stats.

Dated at Madison, Wisconsin, this 21st day of December 1993.

Randy Blumer
Deputy Commissioner of Insurance



812R8
12/22/93