STATE OF WISCONSIN

Fact Sheet on Standard Health Insurance Forms

OFFICE OF THE COMMISSIONER OF INSURANCE PI-083 (R 05/2004)

Does Wisconsin have laws relating to the forms providers and insurers are required to use in submitting and paying health insurance claims?

Yes. The legislature, in 1991, required the Office of the Commissioner of Insurance (OCI), by rule, to establish a standardized billing format for health care services that providers would be required to use for all printed billing forms.

Section Ins 3.65, Wis. Adm. Code, (http://www.legis.state.wi.us/rsb/code/ins/ins003.pdf) became effective on July 1, 1993, and applies to claims filed after that date.

What forms are providers required to use?

- Individual providers are required to file health insurance claims using the most current form of the HCFA 1500 form and to complete it according to the instructions of the Health Care Financing Administration (HCFA).
- Institutional providers are required to file claims using the most current form of the HCFA 1450 (UB-92) and to complete it according to the instructions in the Wisconsin uniform billing manual.
- Dentists are required to file claims using the most current form of the American Dental Association (ADA) dental claim form.

Are providers required to file claims for patients?

No, but the provider is required to give the patient a completed form to file with the insurer.

How are individual providers defined?

Individual providers include:

acupuncturists, chiropractors, marriage and family therapists, nurses, occupational therapists, occupational therapy assistants, optometrists, physical therapists, physicians, podiatrists, professional counselors, psychologists, respiratory care practitioners, social workers, speech-language pathologist, and staff model health maintenance organizations.

Providers of emergency medical services are not included in the definition.

How are institutional providers defined?

Institutional providers include:

- inpatient health care facilities
- community-based residential facilities
- hospices.

What coding systems are insurers permitted to require on the forms?

For the HCFA 1500 form, the only coding systems insurers may require providers to use are the HCPCS codes, the ICD-9-CM codes, and the DSM-III-R codes.

For the HCFA 1450 form, the only codes insurers may require providers to use are ICD-9-CM codes, revenue codes and, if charges for professional health care provider services are included, HCPCS or DSM-III-R codes.

The only codes an insurer may require on a dental claim form are CDT-1 codes and CPT-4 codes.

Are insurers required to accept these forms?

Yes. The rule requires insurers to accept the standardized forms as proof of a claim.

May insurers require additional information?

Insurers may require additional information to determine medical necessity or the nature of the service or procedure provided if the information conveyed by standard coding is insufficient to

enable an insurer to determine eligibility for payment. The 30-day period for payment of a claim begins when the insurer has sufficient information to determine eligibility for payment.

What forms are insurers required to use in paying claims?

When an insurer pays a claim to a health care provider, the insurer is required to use a standardized **remittance advice form** as described in s. Ins 3.651, Wis. Adm. Code.

The form has to include:

- The insurer's name, address, and telephone number of a section of the insurer designated to handle questions and appeals from health care providers.
- The insured's name and policy or certificate number.
- The name of the patient and the patient's identification and account number if it has been supplied by the health care provider.
- The following information for each claim on a single line:
  - √ Date(s) of service;
  - √ CPT-4, HCPCS, or CDT-1 code;
  - √ Amount charged by the provider;
  - √ Amount allowed by the insurer;
  - √ Deductible amount;
  - √ Copayment amount;
  - √ Amount of any contractual discount;
  - √ Claim adjustment reason code;
  - √ Amount paid by insurer toward the charge.

A copy of the administrative rule, s. Ins 3.651, Wis. Adm. Code, (http://www.legis.state.wi.us/rsb/code/ins/ins003.pdf) that describes the standardized remittance advice form and permitted exceptions to the format of the form is available from the Central Files section of OCI at (608) 264-8110.

Are there other requirements for this form?

Yes. If an insurer includes claims for more than one policyholder or certificateholder on the same remittance advice form, all claims for that policyholder or certificateholder must be grouped together.

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

Insurers are not required to include a column for any item that is not applicable.

Insurers may include additional columns if necessary but these columns may only be inserted before the claim adjustment reason code column.

Insurers are required to send the remittance advice form to the payee designated on the claim form.

What are the "claim adjustment reason codes"?

The claims adjustment reason codes are the claim disposition codes of the American National Standards Institute (ANSI) Accredited Standards Committee X12 (ASC X12).

A current copy of the OCI form (OCI 17-007) that describes codes and their narrative explanation is available from the Central Files section of OCI at (608) 264-8110. The form is updated semiannually by OCI.

Are there requirements for the Explanation of Benefits forms that insurers send to insureds?

Yes. Although there is no standard format for the **Explanation of Benefits**, insurers are required to include the following information on the forms they send to insureds:

- The insurer's name and address and the telephone number of the section of the insurer designated to handle questions and appeals from insureds relating to payments;
- The insured's name, address, and policy number, certificate number, or both;
- A statement as to whether payment accompanies the form, payment has been made to the health care provider, or payment has been denied;
- The name of each person for whom claim information is being reported;

- For each patient listed, all of the following information on a single line:

  √ Name of provider as indicated on the claim form;
  √ Date the service was provided or procedure performed;
  √ CPT-4, HCPCS, or CDT-1 codes;
  √ Amount charged by the health care provider if the insured may be liable for any of the difference between the amount charged and the amount allowed by the insurer;
  √ Amount allowed by the insurer;
  √ Claim adjustment reason codes and narrative explanation;
  √ Applicable deductible and copayment amounts;
  √ Amount paid by insurer;
  √ General description of each procedure performed or service provided;
  √ If applicable, the remaining deductible, out-of-pocket amount, lifetime limit or annual benefit limit.

Insurers are not required to provide an Explanation of Benefits if the insured has no liability for payment or is liable only for a copayment unless requested to do so.

If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not receive satisfactory answers, contact the Office of the Commissioner of Insurance (OCI).

For information on how to file insurance complaints call:

(608) 266-0103 (In Madison)
or
1-800-236-8517 (Statewide)

Mailing Address
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Electronic Mail
ocicomplaints@wisconsin.gov
(please indicate your name, phone number, and e-mail address)

OCI's World Wide Web Home Page
http://oci.wi.gov

A copy of OCI's complaint form is available on OCI's Web site. You can print it, complete it, and return it to the above mailing address.

Copies of OCI publications are available on-line on OCI's Web site.

Deaf, hearing, or speech impaired callers may reach OCI through WI TRS

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