Ins 3.51 Reports by individual practice associations. (1) DEFINITIONS. For the purpose of this section only:

(a) "Accountant" means an independent certified public accountant who is duly registered to practice and in good standing under the laws of this state or a state with similar licensing requirements.

(b) "Individual practice association" means an individual practice association as defined under s. 600.03 (23g), Stats., which contracts with a health maintenance organization insurer or a limited service health organization to provide health care services which are principally physician services.

(c) "Work papers" are the records kept by the accountant of the procedures followed, the tests performed, the information obtained, and conclusions reached pertinent to the examination of the financial statements of the independent practice association. Work papers include, but are not limited to, work programs, analysis, memorandum, letters of confirmation and representation, management letters, abstracts of company documents and schedules or commentaries prepared or obtained by the accountant in the course of the examination of the financial statements of the independent practice association and which support the accountant's opinion.

(2) FILING OF ANNUAL AUDITED FINANCIAL REPORTS. Unless otherwise ordered by the commissioner, an individual practice association shall file an annual audited financial report with the commissioner within 180 days after the end of each individual practice association's fiscal year. This section applies to individual practice associations for fiscal years terminating on or after March 31, 1991. The annual audited financial report shall report the assets, liabilities and net worth; the results of operations; and the changes in net worth for the fiscal year then ended on the accrual basis in conformity with generally accepted accounting practices. The annual audited financial report shall not be presented on the cash basis or the income tax basis or any other basis that does not fully account for all the independent practice association's liabilities incurred as of the end of the fiscal year. The annual audited financial report shall include all of the following:

(a) Report of independent certified public accountant.

(b) Balance sheet.

(c) Statement of gain or loss from operations.

(d) Statement of changes in financial position.

(e) Statement of changes in net worth.

(f) Notes to the financial statements. These notes shall include those needed for fair presentation and disclosure.

(g) Supplemental data and information which the commissioner may from time to time require to be disclosed.

(3) SCOPE OF AUDIT AND REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANT. Financial statements filed under sub. (2) shall be audited by an independent certified public accountant. The audit shall be conducted in accordance with generally accepted auditing standards. The commissioner may from time to time require that additional auditing procedures be observed by the accountant in the audit of the financial statements of the independent practice association under this rule.

(4) AVAILABILITY AND MAINTENANCE OF CPA WORK PAPERS. (a) An independent practice association required to file an audited financial report under this rule shall, if requested by the office, require the accountant to make available to the office all the work papers prepared in the conduct of the audit. The independent practice association shall require that the accountant retain the audit work papers for a period of not less than 5 years after the period reported.

(b) The office may photocopy pertinent audit work papers. These copies are part of the office's work papers. Audit work papers are confidential unless the commissioner determines disclosure is necessary to carry out the functions of the office.

(5) CONTRACTS. A health maintenance organization insurer contracting with an independent practice association shall include provisions in the contract which are necessary to enable the individual practice association to comply with this section including, but not limited to:

(a) Provisions providing for timely access to records;

(b) Provisions providing for maintenance of necessary records and systems and segregation of records, accounts and assets; and

(c) Other provisions necessary to ensure that the individual practice association operates as an entity distinct from the insurer.

History: Cr. Register, August, 1990, No. 416, eff. 9–1–90.

Ins 3.52 Limited service health organizations. (1) PURPOSE. This section establishes financial and other standards for limited services health organizations doing business in Wisconsin. The requirements in this section are in addition to any other statutory or administrative rule requirements which apply to limited service health organizations.

(2) SCOPE. Except for subs. (4) and (8), this section applies to all limited service health organizations doing business in Wisconsin. Subsections (4) and (8) do not apply to a limited service health organization operated as a line of business of a licensed insurer unless the insurer does substantially all of its business as a limited service health organization.

(3) DEFINITIONS. (a) "Acceptable letter of credit" means a clean, unconditional, irrevocable letter of credit issued by a Wisconsin bank or any other financial institution acceptable to the commissioner which renews on an annual basis for a 3–year term unless written notice of nonrenewal is given to the commissioner and the limited service health organization at least 60 days prior to the renewal date.

(b) "Complaint" means any dissatisfaction about an insurer or its contracted providers expressed by an enrollee.

(c) "Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by a limited service health organization which is expressed in writing by or on behalf of a plan enrollee.

(d) "Limited service health organization" means a health care plan as defined in s. 609.01 (3), Stats.

(4) FINANCIAL REQUIREMENTS. (a) *Minimum capital or permanent surplus.* The minimum capital or permanent surplus requirement for a limited service health organization shall be not less than $75,000.

(b) *Security deposit.* 1. Each limited service health organization shall maintain either a deposit of securities with the state treasurer or an acceptable letter of credit on file with the commissioner's office. The amount of the deposit or letter of credit shall be not less than $75,000 for limited service health organizations. The letter of credit shall be payable to the commissioner whenever rehabilitation or liquidation proceedings are initiated against the limited service health organization.

2. The commissioner may accept the deposit or letter of credit under subd. 1. to satisfy the minimum capital or permanent surplus requirement under par. (a), if the limited service health organization demonstrates to the satisfaction of the commissioner that it does not retain any risk of financial loss because all risk of loss has been transferred to providers through provider agreements.

(c) *Compulsory surplus.* 1. Each limited service health organization shall maintain a compulsory surplus to provide security against contingencies that affect its financial position but which are not fully covered by provider contracts, insolvency insurance, reinsurance, or other forms of financial guarantees. The compulsory surplus is equal to not less than the greater of:

a. 3% of the premiums earned by the limited service health organization in the previous 12 months; or

b. $75,000.

2. The commissioner may accept the deposit or letter of credit under par. (b) to satisfy the compulsory surplus requirement if the limited service health organization demonstrates to the satisfaction of the commissioner that it does not retain any risk of financial loss because all risk of loss has been transferred to providers through provider agreements. The commissioner may, by order, require a higher or lower compulsory surplus or may establish additional factors for determining the amount of compulsory surplus required for a particular limited service health organization.

(d) *Security surplus.* The limited service health organization should maintain a security surplus to provide an ample margin of safety and clearly assure a sound operation. The security surplus of a limited service health organization shall be equal to not less than 110% of compulsory surplus.

(e) *Operating funds.* The limited service health organization shall make arrangements, satisfactory to the commissioner, to provide sufficient funds to finance any operating deficits in the business and to prevent impairment of the insurer's initial capital or permanent surplus or its compulsory surplus. To determine the acceptability of these arrangements the commissioner shall take into account reasonable projections of enrollments, claims and administrative costs, financial guarantees given to the organization, the financial condition of any guarantors and other relevant information.

(f) *Setting greater amounts.* The commissioner may require, based on the actual operating experience of a particular insurer, greater amounts under pars. (a), (d) and (e) on finding that the financial stability of the organization requires it. Higher financial standards may be applied to a limited service health organization which does not transfer all of the risk to individual providers.

(g) *Insolvency protection for policyholders.* Each limited service health organization which provides hospital benefits shall demonstrate that, in the event of an insolvency, enrollees hospitalized at the time of an insolvency will be covered until discharged.

(5) BUSINESS PLAN. All applications for certificates of incorporation and certificates of authority of a limited service health organization shall include a proposed business plan. Limited service health organizations that are not separately licensed shall submit a proposed business plan prior to doing business as a limited service health organization unless the commissioner waives this requirement. In addition to the items listed in ss. 611.13 (2) and 613.13 (1), Stats., the business plan shall contain the following information:

(a) *Identity of organization.* The name and address of the limited service health organization and the names and addresses of individual providers, if any, who control the limited service health organization.

(b) *Organization type.* The type of organization, including information on whether providers will be salaried employes of the organization or individual or group contractors.

(c) *Feasibility study.* A feasibility study which supports the financial and enrollment projections of the plan, including the potential number of enrollees in the geographical service area, the estimated number of enrollees for the first 5 years, the underwriting standards to be applied, and the method of marketing the organization.

(d) *Geographical service area.* The geographical service area by county including a chart showing the number of primary and specialty care providers with locations and service areas by county; the method of handling emergency care, with locations of emergency care facilities; and the method of handling out–of–area services.

(e) *Provider agreements.* The extent to which any of the following are or are not included in provider agreements and the form of any provisions which:

1. Limit the providers' ability to seek reimbursement for covered services from policyholders or enrollees;

2. Permit or require the provider to assume a financial risk in the limited services health organization, including any provisions for assessing the provider, adjusting capitation or fee–for–service rates, or sharing in the earnings or losses of the organization; or

3. Govern amending or terminating the agreement or the effect of amending or terminating the agreement.

(f) *Plan administration.* 1. A copy of the administrative agency contract if management or administrative authority for the operation of the limited service health organization is delegated to a person or organization outside of the limited service health organization. This administration contract shall include a description of the services to be provided, the standards of performance for the administrative agent, the method of payment, including any provisions for the administrative agent to participate in profit or losses in the plan, the duration of the contract and any provisions for modifying, terminating, or renewing the contract.

2. A summary of how the limited service health organization will provide administrative services, including size and qualifications of the administrative staff, and the projected cost of administration in relation to premium income shall accompany the application if a limited service health organization provides its own administrative services and does not delegate these functions to a person or organization outside of the limited service health organization.

(g) *Financial projections.* A summary of current and projected enrollment, income from premiums by type of payor, other income, administrative and other costs, the projected break even point, including the method of funding the accumulated losses until the income and expense reach the break even point, and a summary of the assumptions made in developing projected operating results.

(h) *Financial guarantees.* A summary of all financial guarantees by providers, sponsors, affiliates or parents within a holding company system, or any other guarantees which are intended to ensure the financial success of the plan. Such guarantees include, but are not limited to, hold harmless agreements by providers, insolvency insurance, reinsurance or other guarantees.

(i) *Contracts with enrollees.* A summary of benefits to be offered enrollees including any limitations and exclusions and the renewability of all contracts to be written.

(6) CHANGES IN THE BUSINESS PLAN. All substantial changes, alterations or amendments to the business plan shall be filed with the commissioner at least 30 days prior to their effective date and shall be subject to disapproval by the commissioner. These include changes to articles and bylaws, organization type, geographical service area, provider agreements, provider availability, plan administration, financial projections and guarantees and any other change which might affect the financial solvency of the plan. Any changes in the items listed in sub. (5) (e) shall be filed under this section.

(7) PROVIDER AGREEMENTS. (a) Prior to doing business, all limited service health organizations shall file with the commissioner copies of all executed provider agreements and other contracts covering its liabilities except that a limited service health organization may file a list of providers executing a standard contract and a copy of the form of the contract instead of copies of the individual executed contracts.

(b) A limited service health organization shall maintain executed copies of all provider agreements in its administrative

office and shall make the copies available to the commissioner on request.

(8) OTHER REPORTING REQUIREMENTS. (a) A limited service health organization shall file an annual statement for the preceding year with the commissioner by March 1 of each year and shall put the statement on the current health maintenance organization annual statement blank prepared by the national association of insurance commissioners.

(b) The commissioner may require other reports on a regular or other basis as appropriate.

(9) POLICY AND CERTIFICATE LANGUAGE REQUIREMENTS. Each policy form marketed by a limited service health organization and each certificate given to enrollees shall contain:

(a) A definition of geographical service area, emergency care, urgent care, out–of–area services, dependents and primary provider, if these terms or terms of similar meaning are used in the policy or certificate and have an effect on the benefits covered by the in the text of the policy or certificate if the definition is adequately described in an attachment which is given to all enrollees along with the policy or certificate.

(b) Clear disclosure in the exclusions, limitations, and exceptions section of any provision which limits benefits or access to service. The exclusions, limitations and exceptions which shall be disclosed include those relating to emergency and urgent care, restrictions on the selection of primary or referral providers, restrictions on changing providers during the contract period, out–of–pocket costs including copayments and deductibles, charges for missed appointments or other administrative sanctions, restrictions on access to care if copayments or other charges are not paid, and any restrictions on coverage for dependents who do not reside in the service area.

(10) GRIEVANCE PROCEDURE. (a) A limited service health organization shall investigate each grievance pursuant to s. 609.15 (2), Stats. Each limited service health organization shall develop an internal grievance procedure which shall be described in each policy and certificate issued to enrollees. Policies and certificates shall include a definition of a grievance.

(b) In addition to the notice requirement in par. (a), each time the limited service health organization denies a claim or benefit, including a refusal to refer an enrollee, and each time it initiates disenrollment proceedings under sub. (12) (b) 5., the limited service health organization shall notify the affected enrollee of the right to file a grievance and the procedure to follow. The notification shall state the specific reason for the denial or initiation.

(c) A limited service health organization shall resolve all grievances within 30 calendar days of receiving the grievance. If the limited service health organization is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if the limited service health organization notifies, in writing, the person who filed the grievance that the limited service health organization has not resolved the grievance, when resolution may be expected, and the reason for why additional time is needed.

(d) A grievance procedure shall include a method whereby the enrollee who made the grievance has the right to appear in person before the grievance committee to present written or oral information and to question those people responsible for making the determination which resulted in the grievance. The limited service health organization shall inform the enrollee in writing of the time and place of the meeting at least 7 calendar days before the meeting.

(e) Pars. (b), (c) and (d) do not apply in urgent care situations. Limited service health organizations shall develop a separate grievance procedure for urgent care situations. This procedure shall require a limited service health organization to resolve an urgent care situation grievance within 4 business days of receiving the grievance.

(f) The limited service health organization shall acknowledge a grievance within 10 days of receiving it.

(g) Limited service health organizations shall record, retain, and report records for each complaint and grievance with all of the following requirements:

1. Each limited service health organization shall keep and retain for at least a three–year period a record for each complaint and grievance submitted to the limited service health organization.

2. Each provider contract and administrative services agreement entered into between a limited service health organization and a provider shall contain a provision under which the provider must identify complaints and grievances and forward these complaints and grievances in a timely manner to the limited service health organization for recording and resolution.

3. Each limited service health organization shall submit a grievance experience report required by s. 609.15 (1) (c), Stats., to the commissioner by March 1 of each year. The report shall provide information on grievances received during the previous calendar year that were formally reviewed by a grievance panel of the limited service health organization. For purposes of this report, the limited service health organization shall classify each grievance as follows:

a. Plan administration. A grievance related to plan marketing, policyholder service, billing, underwriting, or similar administrative functions; or

b. Benefit denials. A grievance related to the denial of a benefit, including grievances related to refusals to refer enrollees or provide requested services.

4. Each limited service health organization shall keep together in a central location of the limited service health organization all records on complaints and grievances resolved before a formal review by a grievance panel is completed or in which the enrollee does not pursue a resolution. The limited service health organization shall make these records available for review during examinations by or on request of the commissioner.

(h) The commissioner shall by June 1 of each year prepare a report that summarizes grievance experience reports received by the commissioner from limited service health organizations. The report shall also summarize complaints involving limited service health organizations that were received by the office during the previous calendar year.

(11) OTHER NOTICE REQUIREMENTS. Prior to enrolling members, the limited service health organization shall provide to all prospective group or individual policyholders information on the plan, including information on the services covered, a definition of emergency and out–of–area coverage, names and specific location of providers for each type of service, the cost of the plan, enrollment procedures, and limitations on benefits including limitations on choice of providers and the geographical area served by the organization.

(12) DISENROLLMENT. (a) The limited service health organization shall clearly disclose in the policy and certificate any circumstances under which the limited service health organization may disenroll an enrollee.

(b) The limited service health organization may disenroll a member from the limited service health organization for the following reasons only:

1. The policyholder has failed to pay required premiums by the end of the grace period.

2. The enrollee has committed acts of physical or verbal abuse which pose a threat to providers or other members of the organization.

3. The enrollee has allowed a nonmember to use the limited service health organization's membership card or has knowingly provided fraudulent information in applying for coverage

with the limited service health organization or in receiving services.

4. The enrollee has moved outside of the geographical service area of the organization.

5. The enrollee is unable to establish or maintain a satisfactory provider–patient relationship with the provider responsible for the enrollee's care. Disenrollment of an enrollee for this reason shall be permitted only if the limited service health organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care provider, made a reasonable effort to assist the enrollee in establishing a satisfactory provider–patient relationship and informed the enrollee that he or she may file a grievance on this matter.

(c) A limited service health organization that has disenrolled an enrollee for any reason except failure to pay required premiums shall make arrangements to provide similar insurance coverage to the enrollee. In the case of group certificate holders this insurance coverage shall be continued until the person is able to find similar coverage or until the next opportunity to change insurers, whichever comes first. In the case of an enrollee covered on an individual basis, coverage shall be continued until the anniversary date of the policy or for one year, whichever is earlier.

(13) TIME PERIOD FOR REVIEW. In accordance with s. 227.116, Stats., the commissioner shall review and make a determination on an application for a certificate of authority within 60 business days after it has been received.

(14) Subs. (9), (10), (11) and (12) shall apply to all policies issued or renewed on or after January 1, 1987.

Note: Section Ins 3.51 shall not apply to policies issued or renewed before January 1, 1987.

Note: A copy of the grievance experience report form required under sub. (10) (g) 3, OCI 26–004, may be obtained from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, WI 53707–7873.

History: Cr. Register, November, 1986, No. 371, eff. 12–1–86; renum. (3) (b) and (10) (c) to be (3) (d) and (10) (f), r. (10) (d), cr. (3) (b) and (c), (10) (c) to (e), (g) and (h), am. (10) (a) and (b), Register, October, 1989, No. 406, eff. 1–1–90; renum. from Ins 3.51, Register, August, 1990, No. 416, eff. 9–1–90.

Ins 3.53 HIV testing. (1) FINDINGS. The tests listed in sub. (4) (e) 1. to 3. have been specified by the state epidemiologist in part C of a report entitled "Validated positive tests and medically significant and sufficiently reliable tests to detect the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV," dated August 31, 1990. The commissioner of insurance, therefore, finds that these tests are sufficiently reliable for use in underwriting individual life, accident and health insurance policies.

(2) PURPOSES. The purposes of this section are:

(a) To implement s. 631.90 (3) (a), Stats.

(b) To establish procedures for insurers to use in obtaining informed consent for HIV testing and informing individuals of the results of a positive HIV test.

(c) To ensure the confidentiality of HIV test results.

(d) To restrict the use of certain information on HIV testing in underwriting group life, accident and health insurance policies.

(3) DEFINITIONS. In this section:

(a) "AIDS" means acquired immunodeficiency syndrome.

(b) "AIDS service organization" means a community–based organization in this state that provides AIDS prevention and education services to the general public and offers direct support services to persons with HIV infection at no cost.

(c) "ELISA" means enzyme–linked immunosorbent assay.

(d) "FDA–licensed test" means a test of a single whole blood, serum or plasma specimen which has been approved by the federal food and drug administration.

(e) "Health care provider" has the meaning given under s. 146.81 (1), Stats.

(f) "HIV" has the meaning given under s. 631.90 (1), Stats.

(g) "Medical information bureau, inc." means the nonprofit Delaware incorporated trade association, the members of which are life insurance companies, that operates an information exchange on behalf of its members.

(h) "State epidemiologist" has the meaning given under s. 146.025 (1) (f), Stats.

(i) "Wisconsin AIDSline" means the statewide AIDS information and medical referral service.

(4) TESTING; USE; PROHIBITIONS. (a) For use in underwriting an individual life, accident or health insurance policy, an insurer may require that the person to be insured be tested, at the insurer's expense, for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV.

(b) An insurer that requires a test under par. (a) shall, prior to testing, obtain a signed consent form, in substantially the format specified in Appendix A, either from the person to be tested or from one of the following if the specified condition exists:

1. The person's parent or guardian, if the person is under 14 years of age.

2. The person's guardian, if the person is adjudged incompetent under ch. 880, Stats.

3. The person's health care agent, as defined in s. 155.01 (4), Stats., if the person has been found to be incapacitated under s. 155.05 (2), Stats.

(c) The insurer shall provide a copy of the consent form to the person who signed it and shall maintain a copy of each consent form for at least one year.

(d) The insurer shall provide with the consent form a copy of the document, "Resources for persons with a positive HIV test/The implications of testing positive for HIV." Each insurer shall either obtain copies of the document from the office of the commissioner of insurance or reproduce the document itself. If the document is revised, the insurer shall begin using the revised version no later than 30 days after receiving notice of the revision from the office of the commissioner of insurance.

Note: The document referred to in this paragraph is form number OCI 17–001. It may be obtained from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, Wisconsin 53707–7873.

(e) The only tests an insurer may use under par. (a) are the following:

1. An FDA–licensed test that is positive for the presence of an HIV antigen.

2. An FDA–licensed ELISA test that is reactive for the presence of an antibody to HIV at least twice, followed by a reactive western blot test.

3. An FDA–licensed latex agglutination test that is positive for the presence of an antibody to HIV at least once, followed by a reactive western blot test.

(f) For purposes of par. (e) 2. and 3., a western blot test is reactive when any 2 of the following protein or glycoprotein bands are present:

1. p24.

2. gp41.

3. gp120 or gp160.

Note: Because of the difficulty of distinguishing the gp120 band from the gp160 band, the state epidemiologist has determined that the 2 glycoprotein bands may be considered as one reactant for the purpose of interpreting a western blot test.

(g) A test under par. (e) shall be performed by a laboratory that participates in and satisfies the standards of a generally recognized HIV proficiency testing program, including a program conducted by the federal centers for disease control, the American association of bioanalysts, the college of American pathologists or a similar program with specifications that meet the standards of those programs.

Note: An insurer may use any of the tests described in pars. (e) to (g), in underwriting individual life, accident and health insurance applications on and after May 1, 1991.

(h) 1. An insurer that uses an application asking whether the person to be insured has been tested for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV may ask only whether the person has been tested using one or more of the tests specified in par. (e).

2. Notwithstanding subd. 1., the insurer may not require or request the disclosure of any information as to whether the person to be insured has been tested at an anonymous counseling and testing site designated by the state epidemiologist or at a similar facility in another jurisdiction, or to reveal the results of such a test.

(5) POSITIVE TEST RESULT; INSURER'S OBLIGATION. (a) If a test under sub. (4) (e) is positive and, in the normal course of underwriting, affects the issuance or terms of the policy, the insurer shall provide written notice to the person who signed the consent form that the person tested does not meet the insurer's usual underwriting criteria because of a test result. The insurer shall request that the person provide informed consent for disclosure of the test result to a health care provider with whom the person wants to discuss the test result.

(b) If informed consent for disclosure is obtained, the insurer shall provide the designated health care provider with the test result. If the person refuses to give informed consent for disclosure, the insurer shall, upon the person's request, provide the person who signed the consent form with the test result. The insurer shall include with the report of the test result all of the following:

1. A statement that the person should contact a private health care provider, a public health clinic, an AIDS service organization or the Wisconsin AIDSline for information on the medical implications of a positive test, the desirability of further independent testing and the availability of anonymous testing.

2. The toll–free telephone number of the Wisconsin AIDSline.

3. Copies of the document specified in sub. (4) (d).

(6) CONFIDENTIALITY OF TEST RESULTS. An insurer that requires a person to be tested under sub. (4) (a) may disclose the test result only as described in the consent form obtained under sub. (4) (b) or with written consent for disclosure signed by the person tested or a person specified in sub. (4) (b) 1. to 3.

(7) GROUP POLICIES; ADDITIONAL PROHIBITION. In underwriting group life, accident or health insurance on an individual basis, in addition to the restrictions specified in s. 631.90 (2), Stats., an insurer may not use or obtain from any source, including the medical information bureau, inc., any of the following:

(a) The results of a person's test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV.

(b) Any other information on whether the person has been tested for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV.

History: Cr. Register, May, 1987, No. 377, eff. 6–1–87; r. and recr. Register, April, 1991, No. 424, eff. 5–1–91.

Ins 3.53 APPENDIX A

[Insurer name and address]

WISCONSIN NOTICE AND CONSENT FOR AIDS–RELATED BLOOD TEST

REQUEST FOR CONSENT FOR TESTING

To evaluate your insurability, (insurer name) (Insurer) requests that you provide a sample of your blood for testing and analysis, to determine the presence of human immunodeficiency virus (HIV) antibody or antigens. By signing and dating this form, you agree that this test may be done and that underwriting decisions may be based on the test results. A licensed laboratory will perform one or more tests approved by the Wisconsin Commissioner of Insurance.

PRETESTING CONSIDERATION

Many public health organizations recommend that, if you have any reason to believe you may have been exposed to HIV, you become informed about the implications of the test before being tested. You may obtain information about HIV and counseling from a private health care provider, a public health clinic, or one of the AIDS service organizations on the attached list. You may also wish to obtain an HIV test from an anonymous HIV counseling and testing site before signing this consent form. The Insurer is prohibited from asking you whether you have been tested at an anonymous HIV counseling and testing site and from obtaining the results of such a test. **For further information on these options, contact the Wisconsin AIDSline at 1–800–334–2437.**

MEANING OF POSITIVE TEST RESULTS

Any test administered is not a test for AIDS. It is a test for antibodies to or antigens of HIV, the causative agent for AIDS, and shows whether you have been infected by the virus. A positive test result may have an effect on your ability to obtain insurance. A positive test result does not mean that you have AIDS, but it does mean that you are at a seriously increased risk of developing problems with your immune system. HIV tests are very sensitive and specific. Errors are rare but they can occur. If your test result is positive, you may wish to consider further independent testing from your physician, a public health clinic, or an anonymous HIV counseling and testing site. **HIV testing may be arranged by calling the Wisconsin AIDSline at 1–800–334–2437.**

NOTIFICATION OF TEST RESULTS

If your HIV test result is negative, no routine notification will be sent to you. If your HIV test result is other than normal, the Insurer will contact you and ask for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the test results.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The laboratory that does the testing will report the result to the Insurer. If necessary to process your application, the Insurer may disclose your test result to another entity such as a contractor, affiliate, or reinsurer. If your HIV test is positive, the Insurer may report it to the Medical Information Bureau (MIB, Inc.), as described in the notice given to you at the time of application. If your HIV test is negative, no report about it will be made to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. These organizations may not disclose the fact that the test has been done or the result of the test except as permitted by law or authorized in writing by you.

CONSENT

I have read and I understand this notice and consent for AIDS–related blood testing. I voluntarily consent to the withdrawal of my blood, the testing of that blood, and the disclosure of the test result as described above. A photocopy or facsimile of this form will be as valid as the original.

_____/_____

Signature of Proposed Insured or Parent, Guardian, or Health Care Agent/Date

_____

Name of Proposed Insured (Print)

_____

Date of Birth

_____

Address

_____

City, State, and Zip Code

Ins 3.54 Home health care benefits under disability insurance policies. (1) PURPOSE. This section implements and interprets ss. 628.34 (1) and (12), 631.20 and 632.895 (1) and (2), Stats., for the purpose of facilitating the administration of claims for coverage of home health care under disability insurance policies and the review of policy forms. The commissioner of insurance shall disapprove a policy under s. 631.20, Stats., if that policy does not meet the minimum requirements specified in this section.

(2) SCOPE. This section applies to disability insurance policies.

(3) DEFINITIONS. In this section:

(a) "Disability insurance policy" means a disability insurance policy as defined under s. 632.895 (1) (a), Stats., which provides coverage of expenses incurred for in–patient hospital care.

(b) "Home health aide services" means nonmedical services performed by a home health aide which:

1. Are not required to be performed by a registered nurse or licensed practical nurse; and

2. Primarily aid the patient in performing normal activities of daily living.

(c) "Home care visits" means the period of a visit to provide home care, without limit on the duration of the visit, except each consecutive 4 hours in a 24–hour period of home health aide services is one visit.

(d) "Medically necessary" means that the service or supply is:

1. Required to diagnose or treat an injury or sickness and shall be performed or prescribed by the physician;

2. Consistent with the diagnosis and treatment of the sickness or injury;

3. In accordance with generally accepted standards of medical practice; and

4. Not solely for the convenience of the insured or the physician.

(4) MINIMUM REQUIREMENTS. (a) All disability insurance policies including, but not limited to, medicare supplement or replacement policies, shall provide a minimum of 40 home care visits in a consecutive 12–month period for each person covered under the policy and shall make available coverage for supplemental home care visits as required by s. 632.895 (2) (e), Stats.

(b) An insurer shall review each home care claim under a disability insurance policy and may not deny coverage of a home care claim based solely on Medicare's denial of benefits.

(c) An insurer may deny coverage of all or a portion of a home health aide service visit because the visit is not medically necessary, not appropriately included in the home care plan or not necessary to prevent or postpone confinement in a hospital or skilled nursing facility only if:

1. The insurer has a reasonable, and documented factual basis for the determination; and

2. The basis for the determination is communicated to the insured in writing.

(d) In determining whether a home care claim, including a claim for home health aide services, is reimbursable under a disability insurance policy, an insurer may apply claim review criteria to determine that home is an appropriate treatment setting for the patient and that it is not reasonable to expect the patient to obtain medically necessary services or supplies on an outpatient basis, subject to the requirements of s. 632.895 (2) (g), Stats.

(e) An insurer shall disclose and clearly define the home care benefits and limitations in a disability insurance policy, certificate and outline of coverage. An insurer may not use the terms "homebound"or "custodial" in the sections of a policy describing home care benefits, exclusions, limitations, or reductions.

(f) In determining whether a home care claim under a disability insurance policy involves medically necessary part–time or intermittent care, an insurer shall give due consideration to the circumstances of each claimant and may not make arbitrary decisions concerning the number of home care visits within a given period which the insurer will reimburse. An insurer may not deny a claim for home care visits without properly reviewing and giving due consideration to the plan of care established by the attending physician under s. 632.895 (1) (b), Stats. An insurer may use claim review criteria based on the number of home care visits in a period for the purpose of determining whether a more thorough review of a home care claim or plan is conducted.

(g) An insurer may use claim review criteria under par. (d) or (f) only if the criteria and review process do not violate s. Ins 6.11. An insurer shall comply with s. 628.34 (1), Stats., when communicating claim review criteria to applicants, insureds, providers or the public.

History: Cr. Register, April, 1976, No. 376, eff. 6–1–87.

Ins 3.55 Benefit appeals under long–term care policies, life insurance–long–term care coverage and Medicare replacement or supplement policies. (1) PURPOSE. This section implements and interprets s. 632.84, Stats., for the purpose of establishing minimum requirements for the internal procedure for benefit appeals that insurers shall provide in long–term care policies, life insurance–long–term care coverage and Medicare replacement or supplement policies. This section also facilitates the review by the commissioner of these policy forms.

(2) SCOPE. This section applies to individual and group nursing home insurance policies and Medicare replacement or supplement policies issued or renewed on or after August 1, 1988, and to long–term care policies and life insurance–long–term care coverage issued or renewed on and after June 1, 1991, except for policies or coverage exempt under s. Ins 3.455 (2) (b). This section does not apply to a health maintenance organization, limited service health organization or preferred provider plan, as those are defined in s. 609.01, Stats.

(3) DEFINITIONS. In this section:

(a) "Benefit appeal" means a request for further consideration of actions involving the denial of a benefit.

(b) "Denial of a benefit" means any denial of a claim, the application of a limitation or exclusion provision, and any refusal to continue coverage.

(c) "Internal procedure" means the insurer's written procedure for handling benefit appeals.

(cg) "Life insurance–long–term care coverage" has the meaning provided under s. Ins 3.46 (3) (d).

(cm) "Long–term care policy" has the meaning provided under s. Ins 3.46 (3) (e).

(d) "Medicare replacement policy" has the meaning given in s. 600.03 (28p), Stats.

(e) "Medicare supplement policy" has the meaning given in s. 600.03 (28r), Stats.

(4) MINIMUM REQUIREMENTS. (a) Pursuant to s. 632.84 (2), Stats., an insurer shall include in any long–term care policy, life insurance–long–term care coverage and any Medicare replacement or supplement policy an internal procedure for benefit appeals.

(b) The insurer shall provide the policyholder and insured with a written description of the benefit appeals internal procedure at the time the insurer gives notice of the denial of a benefit. The written description shall include the name, address, and phone number of the individual designated by the insurer to be responsible for administering the benefit appeals internal procedure.

(c) An insurer shall describe the benefit appeals internal procedure in every policy, group certificate, and outline of coverage. The description shall include a statement on the following:

1. The insured's right to submit a written request in any form, including supporting material, for review by the insurer of the denial of a benefit under the policy; and

2. The insured's right to receive notification of the disposition of the review within 30 days of the insurer's receipt of the benefit appeal.

(d) An insurer shall retain records pertaining to a benefit appeal filed and the disposition of this appeal for at least 3 years from the date that the insurer files with the commissioner under sub. (5) the annual report in which information concerning the appeal is reported.

(e) No insurer may impose a time limit for filing a benefit appeal that is less than 3 years from the date the insurer gives notice of the denial of a benefit.

(f) An insurer shall make any internal procedure established pursuant to s. 632.84, Stats., available to the commissioner upon request and in as much detail as the commissioner requests.

(5) REPORTS TO THE COMMISSIONER. An insurer shall report to the commissioner by March 31 of each year a summary of all benefit appeals filed during the previous calendar year and the disposition of these appeals, including:

(a) The name of the individual designated by the insurer to be responsible for administering the benefit appeals internal procedure;

(b) Changes made in the administration of claims as a result of the review of benefit appeals;

(c) For each benefit appeal, the line of coverage;

(d) The date each benefit appeal was filed and, if within the calendar year, subsequently resolved;

(e) The date each benefit appeal carried over from the previous calendar year was resolved;

(f) The nature of each benefit appeal; and

(g) A summary of each benefit appeal resolution.

(6) POLICY DISAPPROVAL. The commissioner shall disapprove a policy under s. 631.20, Stats., if that policy does not meet the minimum requirements specified in this section.

History: Cr. Register, May, 1989, No. 401, eff. 1–1–90; am. (1), (2) and (4) (a), r. (3) (f), cr. (3) (cg) and (cm), Register, April, 1991, No. 424, eff. 6–1–91.

Ins 3.60 Disclosure of information on health care claim settlements. (1) PURPOSE. This section implements and interprets s. 628.34 (1) (a) and (12), Stats., for the purpose of allowing insureds and providers access to information on the methodology health insurers use to determine the eligible amount of a health insurance claim and permitting insureds to obtain estimates of amounts that their insurers will pay for specific health care procedures and services.

(2) DEFINITIONS. In this section:

(a) "C.D.T." means the American dental association's current dental terminology.

(b) "C.P.T." means the American medical association's current procedural terminology.

(c) "Provider" means a licensed health care professional.

(3) APPLICABILITY. (a) This section applies to an individual or group health insurance contract or certificate of individual coverage issued in this state that provides for settlement of claims based on a specific methodology, including but not limited to, usual, customary and reasonable charges or prevailing rate in the community, by which the insurer determines the eligible amount of a provider's charge.

(b) This section applies to a health maintenance organization to the extent that it makes claim settlement determinations for out–of–plan services as described in par. (a).

(4) DATA REQUIREMENTS. Any insurer that issues a policy or certificate subject to this section shall base its specific methodology on a data base that meets all of the following conditions:

(a) The fees in the data base shall accurately reflect the amounts charged by providers for health care procedures and services rather than amounts paid to or collected by providers, and may not include any medicare charges or discounted charges from preferred provider organization providers.

(b) The data base shall be capable of all of the following:

1. Compiling and sorting information for providers by C.D.T. code, C.P.T. code or other similar coding acceptable to the commissioner of insurance.

2. Compiling and sorting by zip code or other regional basis, so that charges may be based on the smallest geographic area that will generate a statistically credible claims distribution.

(c) The data base shall be updated at least every 6 months.

(d) No data in the data base at the time of an update under par. (c) may be older than 18 months.

(e) If the insurer uses an outside vendor's data base the insurer may supplement it with data from the insurer's own claim experience.

(f) An insurer may supplement a statistical data base with other information that establishes that providers accept as payment without balance billing amounts less than their initial or represented charge only if:

1. The insurer makes the disclosure required under sub. (6) (a) 1. e.;

2. The information establishes that the provider generally and as a practice accepts the payment without balance billing regardless of which insurer is providing coverage; and

3. The information is no older than 18 months before the date of an update under par. (c), clearly establishes the practice, is documented and is maintained in the insurer's records during the period that the information is used and for 2 years after that date.

(5) DISCLOSURE REQUIREMENTS UPON ISSUANCE OF POLICY. (a) Each policy and certificate subject to this section shall include all of the following:

1. A clear statement, printed prominently on the first page of the policy or in the form of a sticker, letter or other form included with the policy, that the insurer settles claims based on a specific methodology and that the eligible amount of a claim, as determined by the specific methodology, may be less than the provider's billed charge. This subdivision does not apply to a closed panel health maintenance organization that does not provide coverage for nonemergency services by noncontracted providers.

2. If the policy or certificate includes a provision offering to defend the insured if a provider attempts to collect any amount in excess of that determined by the insurer's specific methodology, less coinsurance and deductibles, a clear statement that such a provision does not apply if the insured signs a separate agreement with the provider to pay any balance due.

(b) At the time a policy or certificate is issued, the insurer shall provide the policyholder or certificate holder with the telephone number of a contact person or section of the company that can furnish insureds with the information required to be disclosed under sub. (6).

(6) REQUESTS FOR DISCLOSURE. (a) Each insurer issuing a policy or certificate subject to this section shall, upon request, provide the insured with any of the following:

1. A description of the insurer's specific methodology including, but not limited to, the following:

a. The source of the data used, such as the insurer's claim experience, trade association's data, an expert panel of providers or other source.

b. How frequently the data base is updated.

c. The geographic area used in determining the eligible amount.

d. If applicable, the percentile used to determine usual, customary and reasonable charges.

e. The conditions and procedures under which a statistical data base is supplemented under sub. (4) (f).

2. The amount allowable under the insurer's guidelines for determination of the eligible amount of a provider's charge for a specific health care procedure or service in a given geographic area. The insurer is required to disclose the specific amount which is an allowable charge under the insurer's guidelines only if the provider's charge exceeds the allowable charge under the guidelines. The estimate may be in the form of a range of payment or maximum payment.

(b) Paragraph (a) does not require an insurer to disclose specifically enumerated proprietary information prohibited from disclosure by a contract between the insurer and the source of the data in the data base.

(c) A request under par. (a) may be oral or written. The insurer may require the insured to provide reasonably specific details, including the provider's estimated charge, and the C.P.T. or C.D.T. code, about the health care procedure or service before responding to the request. The response may be oral or written and the insurer shall respond within 5 working days after the date it receives a sufficient request. As part of the response, the insurer shall inform the requester of all of the following:

1. That the policy benefits are available only to individuals who are eligible for benefits at the time a health care procedure or service is provided.

2. That policy provisions including, but not limited to, preexisting condition and contestable clauses and medical necessity requirements, may cause the insurer to deny a claim.

3. That policy limitations including, but not limited to copayments and deductibles, may reduce the amount the insurer will pay for a health care procedure or service.

4. That a policy may contain exclusions from coverage for specified health care procedures or services.

(d) An insurer that provides a good faith estimate under par. (a) 2., based on the information provided at the time the estimate is requested, is not bound by the estimate.

(e) Upon request, an insurer shall provide the commissioner of insurance with information concerning the insurer's specific methodology.

(7) DISCLOSURE ACCOMPANYING PAYMENT. If an insurer, based on its specific methodology, determines that the eligible amount of a claim is less than the amount billed, the insurer shall disclose with the remittance advice or explanation of benefits form under s. Ins 3.651, which accompanies payment to the provider or the insured, the telephone number of a contact person or section of the company from whom the provider or the insured may request the information specified under sub. (6) (a) 1.

(8) VIOLATION. A pattern of providing inaccurate or misleading responses under sub. (6) (c) is a violation of s. 628.34 (1) (a), Stats.

History: Cr. Register, December, 1992, No. 444, eff. 1–1–93; reprinted to correct copy in (4) (d), (6) (a) 2. and (c) (intro.), Register, February, 1993, No. 446; r. and recr. (7), Register, August, 1993, No. 452, eff. 9–1–93.

Ins 3.65 Standardized claim format. (1) PURPOSE; APPLICABILITY. This section implements s. 632.725 (2) (a) and (b), Stats., by designating and establishing requirements for use of the forms that health care providers in this state shall use on and after July 1, 1993, for providing a health insurance claim form directly to a patient or filing a claim with an insurer on behalf of a patient.

(2) DEFINITIONS. In this section and in s. Ins 3.651:

(a) "ADA dental claim form"means the uniform dental claim form approved by the American dental association for use by dentists.

(b) "CDT–1 codes"means the current dental terminology published by the American dental association.

(c) "CPT–4 codes"means the current procedural terminology published by the American medical association.

(d) "DSM–III–R codes"means the American psychiatric association's codes for mental disorders.

(e) "HCFA"means the federal health care financing administration of the U.S. department of health and human services.

(f) "HCFA–1450 form"means the health insurance claim form published by HCFA for use by institutional providers.

(g) "HCFA–1500 form"means the health insurance claim form published by HCFA for use by health care professionals.

(h) "HCPCS codes"means HCFA's common procedure coding system which includes all of the following:

1. Level 1 codes which are the CPT–4 codes.

2. Level 2 codes which are codes for procedures for which there are no CPT–4 codes.

3. Levels 1 and 2 modifiers.

(i) "Health care provider"has the meaning given in s. 632.725 (1), Stats.

(j) "ICD–9–CM codes"means the disease codes in the international classification of diseases, 9th revision, clinical modification published by the U.S. department of health and human services.

(k) "Medicare"means Title XVIII of the federal social security act.

(L) "Medical assistance"means Title XIX of the federal social security act.

(m) "Revenue codes"means the codes which are included in the Wisconsin uniform billing manual and which are established for use by institutional health care providers by the national uniform billing committee.

Note: The publications and forms referred to in subsection (2) may be obtained as follows: HCFA–1500 form and instructions

From the U.S. Government Printing Office, 710 North Capitol Street NW, Washington, DC 20401, all of the following:

HCPCS codes

ICD–9–CM codes

HCFA–1450 form and instructions

From the American Dental Association, 211 East Chicago Avenue, Chicago, IL 60611, both of the following:

CDT–1 codes

ADA dental claim form and CDT–1 User's Manual

From Order Department: OP054192, the American Medical Association, P. O. Box 10950, Chicago, IL 60610: CPT–4 codes

From the American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005: DSM–III–R codes

From the Wisconsin Hospital Association, 5721 Odana Road, Madison, WI 53719: Wisconsin Uniform Billing Manual and revenue codes

(3) USE OF HCFA–1500 FORM. (a) *Required users; instructions.* For providing a health insurance claim form directly to a patient or filing a claim with an insurer on behalf of a patient, all of the following health care providers shall use the format of the HCFA–1500 form, following HCFA's instructions for use:

1. A nurse licensed under ch. 441, Stats.

2. A chiropractor licensed under ch. 446, Stats.

3. A physician, podiatrist or physical therapist licensed under ch. 448, Stats.

4. An occupational therapist, occupational therapy assistant or respiratory care practitioner certified under ch. 448, Stats.

5. An optometrist licensed under ch. 449, Stats.

6. An acupuncturist licensed under ch. 451, Stats.

7. A psychologist licensed under ch. 455, Stats.

8. A speech–language pathologist or audiologist licensed under subch. III of ch. 459, Stats., or a speech and language pathologist licensed by the department of public instruction.

9. A social worker, marriage and family therapist or professional counselor certified under ch. 457, Stats.

10. A partnership of any providers specified under subds. 1. to 9.

11. A corporation of any providers specified under subds. 1. to 9. that provides health care services.

12. An operational cooperative sickness care plan organized under ss. 185.981 to 185.985, Stats., that directly provides services through salaried employes in its own facility.

(b) *Coding requirements.* In addition to HCFA's coding instructions, the following restrictions and conditions apply to the use of the HCFA–1500 form:

1. The only coding systems an insurer may require a health care provider to use are the following:

a. HCPCS codes.

b. ICD–9–CM codes.

c. DSM–III–R codes, if no ICD–9–CM code is available.

2. For anesthesia services for which there is no applicable HCPCS level 1 anesthesia code, a health care provider shall use the applicable HCPCS level 1 surgery code.

3. An insurer may not require a health care provider to use any other verbal descriptor with a code or to furnish additional information with the initial submission of a HCFA–1500 form except under the following circumstances:

a. When the procedure code used describes a treatment or service which is not otherwise classified.

b. When the procedure code is followed by the CPT–4 modifier 22, 52 or 99. A health care provider using the modifier 99 may use item 19 of the HCFA–1500 form to explain the multiple modifiers.

c. When required by a contract between the insurer and health care provider.

4. A health care provider may use item 19 of the HCFA–1500 form to indicate that the form is an amended version of a form previously submitted to the same insurer by inserting the word "amended" in the space provided.

(c) *Use of unique identifiers.* In completing the HCFA–1500 form, the individual or entity filing the claim shall do all of the following:

1. In item 17a, use the unique physician identifier number assigned by HCFA or, if the physician does not have such a number, the physician's taxpayer identification number assigned by the U. S. internal revenue service.

2. In item 33, use both of the following:

a. The name and address of the payee.

b. The unique physician identifier number assigned by HCFA to the individual health care provider who performed the procedure or ordered the service or, if the individual does not have such a number, the individual's taxpayer identification number assigned by the U. S. internal revenue service.

(4) USE OF HCFA–1450 FORM. (a) *Required users; instructions.* For providing a health insurance claim form directly to a patient or filing a claim on behalf of a patient, all of the following health care providers shall use the format of the HCFA–1450 form, following the instructions for use in the Wisconsin uniform billing manual:

1. A hospice licensed under subch. IV of ch. 50, Stats.

2. An inpatient health care facility, as defined in s. 140.86 (1), Stats.

3. A community–based residential facility, as defined in s. 140.85 (1), Stats.

(b) *Coding requirements.* The only coding systems an insurer may require a health care provider to use are the following:

1. ICD–9–CM codes.

2. Revenue codes.

3. If charges for professional health care provider services are included, HCPCS or DSM–III–R codes.

(c) *Claims for outpatient services; supplemental form permitted.* A hospital may use a HCFA–1500 form to supplement a HCFA–1450 form if necessary to complete a claim for outpatient services.

(5) USE OF ADA DENTAL CLAIM FORM. (a) *Required users; instructions.* For providing a health insurance claim form directly to a patient or filing a claim with an insurer on behalf of a patient, a dentist or a corporation or partnership of dentists shall use the format of the ADA dental claim form, following the instructions for use in the American dental association CDT–1 user's manual.

(b) *Coding.* An insurer may not require a dentist to use any code other than the following:

1. CDT–1 codes.

2. CPT–4 codes.

(6) GENERAL PROVISIONS. (a) *Insurers to accept forms.* No insurer may refuse to accept a form specified in sub. (3) (a), (4) (a) or (5) (a) as proof of a claim.

(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 provider had filed a claim on behalf of the patient.

(c) *Insurers may require additional information.* 1. If the information conveyed by standard coding is insufficient to enable an insurer to determine eligibility for payment, the insurer may require a health care provider to furnish additional medical records to determine medical necessity or the nature of the procedure or service provided.

2. The 30–day period allowed for payment of a claim under s. 628.46 (1), Stats., begins when the insurer has sufficient information to determine eligibility for payment.

(d) *Use of current forms and codes.* In complying with this section, a health care provider shall do all of the following that are applicable:

1. Use the most current version of the HCFA–1500 or HCFA–1450 claim form and accompanying instructions by the mandatory effective date HCFA specifies for use in filing medicare claims.

2. Begin using modifications to a required coding system for all billing and claim forms by the mandatory effective date HCFA specifies for use in filing medicare claims.

3. Use the most current version of the ADA dental claim form.

History: Cr. Register, August, 1993, No. 452, eff. 9–1–93; am. (6) (b), Register, February, 1994, No. 458, eff. 3–1–94.

Ins 3.651 Standardized explanation of benefits and remittance advice format. (1) PURPOSE. This section implements s. 632.725 (2) (c), Stats., by prescribing the requirements for the following, to be used by insurers providing health care coverage to one or more residents of this state:

(a) Remittance advice forms that insurers furnish to health care providers.

(b) Explanation of benefits forms that insurers furnish to insureds.

(2) DEFINITIONS. In addition to the definitions in s. Ins 3.65, in this section, "claim adjustment reason codes"means the claim disposition codes of the American national standards institute accredited standards committee X12 (ASC X12).

Note: The claim adjustment reason codes referenced in subsections (2), (3) (b) 4. i., (4) (a) 5. f. and (5), form OCI 17–007, may be obtained from the Office of the Commissioner of Insurance, P. O. Box 7873, 121 East Wilson Street, Madison, Wisconsin 53707–7873.

(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.

Note: If, on March 1, 1994, an insurer has a contract with a health care provider that governs the form and content of remittance advice forms, s. Ins 3.651 (3), as affected March 1, 1994, first applies to the insurer on the date the contract is renewed, but no later than December 31, 1994.

(4) EXPLANATION OF BENEFITS FOR INSUREDS. (a) The explanation of benefits form for insureds shall include, at a minimum, all of the following:

1. 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.

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

3. A statement as to whether payment accompanies the form, payment has been made to the health care provider or payment has been denied.

4. The last name followed by the first name and middle initial of each patient insured under the policy or certificate for whom claim information is being reported, and the patient account number, if it has been supplied by the health care provider.

5. For each patient listed, all of the following that are applicable, using a single line for each procedure or service:

a. The health care provider as indicated on the claim form.

b. The date the service was provided or procedure performed.

c. The CPT–4, HCPCS or CDT–1 code.

d. The 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.

e. The amount allowed by the insurer. An insurer may modify this requirement if necessary to provide information relating to supplemental insurance.

f. Each claim adjustment reason code, unless the claim is for a dental procedure for which there is no applicable code, in which case the insurer shall provide an appropriate narrative explanation as a replacement for the information required under subd. 7.

g. The applicable deductible amount, if any.

h. The applicable copayment amount, if any.

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

6. A general description of each procedure performed or service provided.

7. 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.

8. Any of the following that apply:

a. The total deductible amount remaining for the policy period.

b. The total out–of–pocket amount remaining for the policy period.

c. The remaining amount of the policy's lifetime limit.

d. The annual benefit limit.

(b) Unless requested by the insured, an insurer is not required to provide an explanation of benefits if the insured has no liability for payment for any procedure or service, or is liable only for a fixed dollar copayment which is payable at the time the procedure or service is provided.

(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.

History: Cr. Register, August, 1993, No. 452, eff. 9–1–93; emer. r. and recr. (3) and (5), renum. (4) (a) 5. b., c. and 8. to 11. to be (4) (a) 5. c., b. and 8. a. to d., am. (4) (a) 6. and 7., cr. (4) (a) 8. (intro.), eff. 10–1–93; r. and recr. (3) and (5), renum. (4) (a) 5. b., c. and 8. to 11. to be (4) (a) 5. c., b. and 8. a. to d., am. (4) (a) 6. and 7., cr. (4) (a) 8. (intro.), Register, February, 1994, No. 458, eff. 3–1–94.