Chapter Ins 3

CASUALTY INSURANCE

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Ins 3.01 Accumulation benefit riders attached to health and accident policies. Except where such rider is used only on a policy replacing the company's own policy, and so recites, no rider providing for accumulations of benefits will be approved for use upon any policy of health and accident insurance, whether it is proposed to issue such rider with or without an additional premium. Such rider operates as an aid to twisting the policies

of another company in such manner as to make its use a direct encouragement of this practice.

Ins 3.02 Automobile fleets, vehicles not included in. Individually owned motor vehicles cannot be included or covered by fleet rates. The determining factor for inclusion under fleet coverage must be ownership and not management or use.

Ins 3.04 Dividends not deducted from premiums in computing loss reserves. Premiums returned to policyholders as dividends may not be deducted from the earned premiums in computing loss reserves under s. 623.04, Stats.

History: 1-2-56; emerg. am. eff. 6-22-76; am. Register, September, 1976, No. 249, eff. 10-1-76.

Ins 3.08 Municipal bond insurance. (1) PURPOSE. This section implements and interprets ss. 601.42, 611.19 (1), 618.21, 623.03, 623.04, 627.05, 628.34 (2), 632.14, and 632.17, Stats., for the purpose of establishing minimum requirements for the transaction of a type of surety insurance known as municipal bond insurance.

(2) SCOPE. This section shall apply to the underwriting, marketing, rating, accounting and reserving activities of insurers which write municipal bond insurance.

(3) DEFINITIONS. (a) "Annual statement" means the fire and casualty annual statement form specified in s. Ins. 7.01 (5) (a).

(b) "Contingency reserve" means a reserve established for the protection of policyholders covered by policies insuring municipal bonds against the effect of excessive losses occurring during adverse economic cycles.

(c) "Cumulative net liability" means one-third of one percent of the insured unpaid principal and insured unpaid interest covered by in-force policies of municipal bond insurance.

(d) "Municipal bonds" means securities which are issued by or on behalf of or are paid or guaranteed by:

1. Any state, territory or possession of the United States of America;

2. Any political subdivision of any such state, territory or possession; or

3. Any agency, authority or corporate or other instrumentality of any one or more of the foregoing, or which are guaranteed by any of the foregoing.

(e) "Municipal bond insurance" means a type of surety insurance authorized by s. Ins 6.75 (2) (g) which is limited to the guaranteeing of the performance and obligations of municipal bonds.

(f) "Municipal bond insurer" means an insurer which issues municipal bond insurance.

(g) "Total net liability" means the average annual amount due, net of reinsurance, for principal and interest on the insured amount of any one issue of municipal bonds.

(h) "Person" means any individual, corporation for profit or not for profit, association, partnership or any other legal entity.

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.

Note: Initial Applicability. This rule first applies to policies issued or renewed on or after May 1, 1993.

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:

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

HCFA-1500 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 insurer 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.

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 subsection (2), 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) An insurer's remittance advice form accompanying payment to a health care provider shall include, at a minimum, all of the following information:

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

2. Before the information required under subds. 3 and 4, the insured's name and address and policy number, certificate number or both.

3. For each insured listed on the remittance advice form, the last name followed by the first name and middle initial of each patient insured under the policy or certificate for whom a claim is being paid, and the patient account number, if it has been supplied by the health care provider.

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

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

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

c. The amount charged by the health care provider.

d. The amount allowed by the insurer.

e. Each claim adjustment reason code.

f. The applicable deductible amount, if any.

g. The applicable copayment amount, if any.

h. The amount of the contractual discount, if any.

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

(b) An insurer shall send the remittance advice form to the payee indicated on the claim form.

(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 CPT-4, HCPCS or CDT-1 code.

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

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. Immediately after each line containing the information required under subd. 5, a general description of the procedure performed or service provided.

7. Immediately after the information required under subd. 6, 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. The total deductible amount remaining for the policy period.

9. The total out-of-pocket amount remaining for the policy period.

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

11. 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) On and after January 1, 1994, an insurer shall use substantially the same formats prescribed in form OCI 26-061 for its remittance advice forms and in form OCI 26-062 for its explanation of benefits forms.

Note: The remittance advice and explanation of benefits formats referenced in sub. (5), forms OCI 26-061 and OCI 26-062, will be available after October 1, 1993, from the Office of the Commissioner of Insurance, P. O. Box 7873, Madison, Wisconsin 53707-7873.

History: Cr. Register, August, 1993, No. 452, eff. 9-1-93.