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.

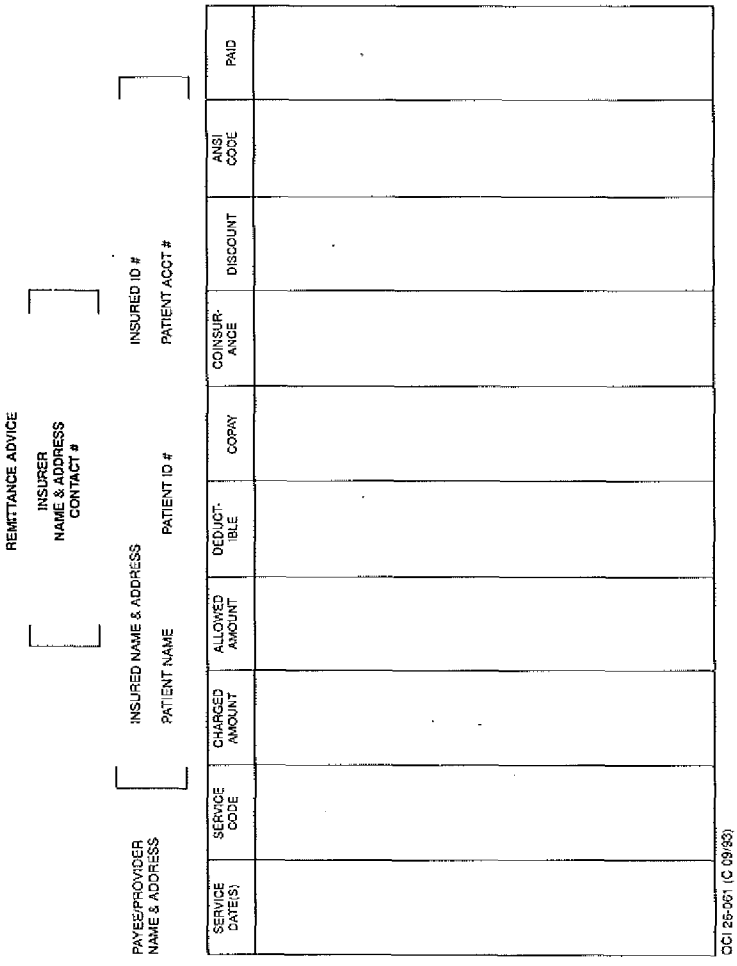
(b) Unless requested by the insured, an insurer is not required to provide an explanation of benefits if the insured has no liability for payment for any procedure or service, or is liable only for a fixed dollar copayment which is payable at the time the procedure or service is provided.

(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.

APPENDIX A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INSURED NAME & ADDRESS
PATIENT NAME
PATIENT ID #
INSURED ID #
PATIENT ACCT #
PAYEE/PROVIDER NAME & ADDRESS
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SERVICE CODE
CHARGED AMOUNT
ALLOWED AMOUNT
DEDUCT-IBLE
COPAY
COINSUR-ANCE
DISCOUNT
ANSI CODE
PAID
DCI 26-061 (C 09/93)