

**WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION**

Form #2

Do Not Mark In This Box

FILED
JUL 21 2 57 PM '00

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: Insurance Commissioner TITLE NUMBER: 114
RULE TYPE: Legislative CITE AUTHORITY: W. Va. Code §§33-2-10 and 33-15B-3
AMENDMENT TO AN EXISTING RULE: YES NO
IF YES, SERIES NUMBER OF RULE BEING AMENDED: 16
TITLE OF RULE BEING AMENDED: Standards for Uniform Health Care Administration
IF NO, SERIES NUMBER OF RULE BEING PROPOSED: _____
TITLE OF RULE BEING PROPOSED: _____

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON Aug. 21, 2000 AT 4:30 p.m. ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS:


Esther T. Van Dall, Associate Counsel

Offices of the Insurance Commis-
sioner

P.O. Box 50540

Charleston, WV 25305-0540

THE ISSUES TO BE HEARD SHALL BE LIMITED TO THIS PROPOSED RULE.


Authorized Signature

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

\$6.00



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

CECIL H. UNDERWOOD
Governor

HANLEY C. CLARK
Insurance Commissioner

July 21, 2000

HAND DELIVERED

Ms. Judy Cooper, Director
Administrative Law Division
Office of Secretary of State
State Capitol
Charleston, West Virginia 25305

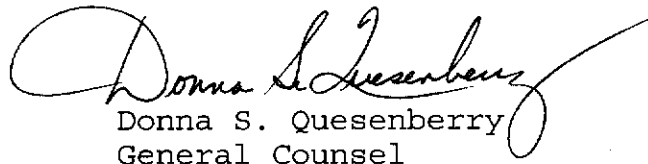
Dear Ms. Cooper:

Enclosed please find for filing one (1) copy of the following:

- 1) Notice of a Comment Period on a Proposed Rule and Consent of Tax and Revenue Cabinet Secretary to Proposed Rule;
- 2) Brief Summary of Rule;
- 3) Statement of Circumstances;
- 4) Fiscal Note;
- 5) The proposed rule entitled "Standards for Uniform Health Care Administration" (Series 16).

Please contact me if further information is required.

Sincerely,


Donna S. Quesenberry
General Counsel

DSQ/jz
Enclosures

Insurance Commissioner
Legislative Rule
Title 114, Series 16

STANDARDS FOR UNIFORM HEALTH CARE ADMINISTRATION

TITLE 114, SERIES 16

BRIEF SUMMARY OF RULE

The existing rule implemented the provisions of Article 15B, Chapter 33 of the West Virginia Code, which directed the Insurance Commissioner to establish guidelines regarding uniform health care administration.

H.B. 4776, effective June 8, 2000, amends Article 15B, Chapter 33 of the West Virginia Code by transferring authority and responsibility to promulgate rules, and develop standard forms and procedures regarding health care administration from the Insurance Commissioner to the West Virginia Health Care Authority.

This proposed amendment will repeal the rule in its entirety without replacement.

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Title 114, Series 16

STANDARDS FOR UNIFORM HEALTH CARE ADMINISTRATION

TITLE 114, SERIES 16

STATEMENT OF CIRCUMSTANCES

This rule implemented the provisions of Article 15B, Chapter 33 of the West Virginia Code, which direct the Insurance Commissioner to establish guidelines regarding uniform health care administration. H.B. 4776, effective June 8, 2000, amends Article 15B, Chapter 33 of the West Virginia Code by transferring authority and responsibility to promulgate rules, and develop standard forms and procedures regarding health care administration from the Insurance Commissioner to the West Virginia Health Care Authority.

This proposed amendment will repeal the rule in its entirety without replacement.

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Standards For Uniform Health Care Administration
Title 114, Series 16

Type of Rule: XX Legislative ___ Interpretive ___ Procedural

Agency: Insurance Commissioner

Address: Post Office Box 50540
1124 Smith Street, Greenbrooke Building
Charleston, West Virginia 25305-0540

=====

1. Effect of Proposed Rule

	ANNUAL FISCAL YEAR				
	Increase	Decrease	Current	Next	Thereafter
ESTIMATED TOTAL COST	None	None	None	None	None
PERSONAL SERVICES	None	None	None	None	None
CURRENT EXPENSE	None	None	None	None	None
REPAIRS AND ALTERNATIONS	None	None	None	None	None
EQUIPMENT	None	None	None	None	None
OTHER	None	None	None	None	None

2. Explanation of above estimates:

This rule will have no fiscal impact on State, local or Federal Government.

3. Objectives of these rules:

The objective of the amendment to the existing rule is to repeal the rule in its entirety without replacement.

Rule Title: Standards For Uniform Health Care Administration
Title 114, Series 16

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

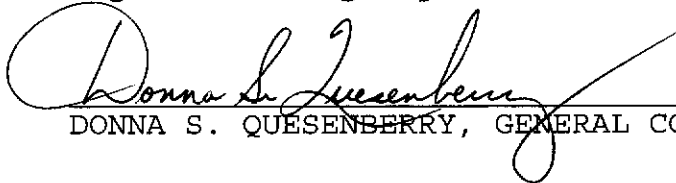
None

C. Economic Impact on Citizens/Public at Large.

None

Date: 7/21/00

Signature of Agency Head or Authorized Representative


DONNA S. QUESENBERY, GENERAL COUNSEL

~~114CSR16~~
~~WEST VIRGINIA LEGISLATIVE RULE~~
~~INSURANCE COMMISSIONER~~

~~SERIES 16~~
~~STANDARDS FOR UNIFORM HEALTH CARE ADMINISTRATION~~

Section

- ~~114-16-1. General~~
- ~~114-16-2. Definitions~~
- ~~114-16-3. Forms~~
- ~~114-16-4. Coding and Terminology~~
- ~~114-16-5. Practices Regarding Reimbursement of Claims and Explanation of Benefits~~
- ~~114-16-6. Additional Information~~
- ~~114-16-7. Severability~~

- ~~Appendix A. Health Care Financing Administration Fifteen Hundred (HCFA 1500) Health Insurance Claim Form~~
- ~~Appendix B. American Hospital Association (AHA) Universal Billing (UB-82) Form~~
- ~~Appendix C. WVMMIS-091 Form for Certain Medical Equipment Claims Not Paid by Medicare~~
- ~~Appendix D. National Council for Prescription Drug Programs (NCPDP) Universal Pharmacy Claim Form~~
- ~~Appendix E. West Virginia Workers' Compensation Fund Pharmacy Invoice WV-401~~
- ~~Appendix F. American Dental Association (ADA) Dental Claim Form~~
- ~~Appendix G. West Virginia Workers' Compensation Fund Services Invoice WC-400~~
- ~~Appendix H. WVMMIS-111 Form for Dental Claims Submitted to Medicaid~~

FILED

114CSR16
~~WEST VIRGINIA LEGISLATIVE RULE~~
~~INSURANCE COMMISSIONER~~

JUL 21 2 54 PM '00

~~SERIES 16~~
~~STANDARDS FOR UNIFORM HEALTH CARE ADMINISTRATION~~

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

~~§ 114-16-1. General~~

~~1.1. Scope. -- This legislative rule applies to all health care providers, applicable state agencies and departments, third-party administrators, and insuring entities in the State. It establishes the acceptance and use throughout the health care system of standard administrative forms, terms and procedures. The rule organizes and streamlines the claims process by establishing standard forms and procedures regarding health care claims. It requires that all insurers, third-party administrators, and health care providers implement and use such standards in a uniform manner.~~

~~1.2. Authority. -- West Virginia Code § 33-2-10 and § 33-15B-3.~~

~~1.3. Filing Date. -- June 18, 1993.~~

~~1.4. Effective Date. -- June 18, 1993.~~

~~1.5. This legislative rule repeals and replaces West Virginia 114CSR16 "Uniform Health Care Claim Forms" filed October 7, 1980 and effective on January 1, 1981.~~

~~§ 114-16-2. Definitions~~

~~2.1. "Health care facility" means any licensed hospital, nursing home, extended care facility, state health or mental institution, clinic, medical corporation, dental corporation, home health care agency, medical equipment vendor or other facility providing professional health care services, supplies, appliances, devices or equipment to an individual during that individual's health care, treatment or confinement.~~

~~2.2. "Health care practitioner" means any medical physician, osteopathic physician, podiatric physician, chiropractic physician, midwife, nurse practitioner, physical therapist, dentist, pharmacist, oral surgeon, or other practitioner who provides health care services, supplies, appliances, devices or equipment.~~

~~2.3. "Health care provider" means a person, partnership,~~

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~~corporation, facility, institution, or other legal entity certified or authorized by law to provide professional health care services, supplies, appliances, devices or equipment to an individual during that individual's health care, treatment or confinement. "Health care provider" encompasses both "health care facility" and "health care practitioner," as those terms are defined herein.~~

~~2.4. "Insuring entity" means any insurer writing or issuing individual or group accident and sickness policies; and hospital service corporation, health service corporation, medical service corporation, or dental service corporation organized in accordance with the provisions of Article One, Chapter 31 or Chapter 33 of the West Virginia Code; any health care corporation organized in accordance with Article 25, Chapter 33 of the West Virginia Code; and health maintenance organization organized in accordance with the provisions of Article 25A, Chapter 33 of the West Virginia Code; any third-party administrator; all applicable state agencies and departments, including, but not limited to, the West Virginia Public Employees Insurance Agency and the West Virginia Workers' Compensation Fund, and Medicaid.~~

~~§ 114-16-3. Forms~~

~~3.1. All health care practitioners shall submit and all insuring entities shall accept third-party payor claims for services, supplies, appliances, devices or equipment on the form known as the current standard Health Care Financing Administration Fifteen Hundred (HCFA 1500) health insurance claim form, designated Appendix A to this rule, or its successor, Provided, That pharmacists and dentists shall submit third-party payor claims in the manner prescribed in Sections 3.3 and 3.4 below, respectively. If practitioners are presently using a HCFA 1500 form other than the most current HCFA 1500 form, they must use and insuring entities must accept the most current HCFA 1500 form by the date prescribed by HCFA.~~

~~3.2. All health care facilities shall submit and all insuring entities shall accept third-party payor claims for services, supplies, appliances, devices or equipment on either the current HCFA 1500 form or its successor or the American Hospital Association's current Uniform Billing form, designated Appendix B hereto, or its successor, as required by the insuring entity; Provided, however, That when Medicare is the primary payor, secondary claims submitted to Medicaid for medical equipment shall~~

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~~be submitted on the current WVMMIS-091 form, designated Appendix C, or its successor.~~

~~3.3. All pharmacists shall submit and all appropriate insuring entities shall accept third-party payor claims for prescription drugs on the current universal pharmacy claim form most recently approved by the National Council for Prescription Drug Programs (NCPDP), designated Appendix D hereto, or its successor, with the exception of prescription drug claims to be submitted to the West Virginia Workers' Compensation Fund and Medicaid, or prescription drug claims to be submitted to an insuring entity which requires its participating pharmacists to submit claims exclusively by computerized electronic transmission, i.e., "point-of-sale" submission.~~

~~3.3.1. All pharmacists shall submit prescription drug claims to the Workers' Compensation Fund on the Pharmacy Invoice WC-401 form, designated Appendix E hereto, or its successor.~~

~~3.3.2. Pharmacists shall submit third-party payor claims for durable medical equipment and disposable medical supplies on the current HCFA 1500 form or its successor.~~

~~3.3.3. Prescription drug claims submitted to Medicaid shall be submitted at "point-of-sale," i.e., through electronic transmission, or, when required by Medicaid, on forms prescribed by Medicaid.~~

~~3.4. All dentists shall submit and all insuring entities shall accept third-party dental claims for services, supplies, appliances, devices or equipment to the appropriate insuring entity on the dental claim form most recently approved by the American Dental Association, designated Appendix F hereto, or its successor, with the exception of claims submitted to the Workers' Compensation Fund and Medicaid.~~

~~3.4.1. For Workers' Compensation claims, all dentists shall submit claims on the form known as Services Invoice WC-400, designated Appendix G hereto, or its successor.~~

~~3.4.2. For Medicaid, all dentists shall submit claims on the WVMMIS-111 form prescribed by Medicaid, designated Appendix H hereto, or its successor.~~

~~3.4.3. Oral surgeons or dentists who submit claims other than dental claims shall submit and all appropriate insuring entities shall accept the current HCFA 1500 form or its successor.~~

~~3.5. Nothing in this rule shall be construed to prohibit voluntary arrangements between insuring entities and health care providers for the submission of claims by computerized electronic transmission.~~

~~§ 114-16-4. Coding and Terminology~~

~~4.1. If the coding systems in subsections 4.1.1. and 4.1.2. below apply to the services, supplies, appliances, devices or equipment provided by a health care provider, the provider shall use and all insuring entities shall accept the following coding systems:~~

~~4.1.1. The current International Classification of Diseases (ICD-9-CM) codes developed by the World Health Organization, or their successors; and~~

~~4.1.2. The current HCFA Common Procedural Coding System (HCPCS), which includes, but is not limited to, the Current Procedural Terminology (CPT) codes developed by the American Medical Association, or its successor.~~

~~4.2. All dentists shall use and all appropriate insuring entities shall accept the latest version of the American Dental Association's Code on Dental Procedures and Nomenclature; Provided, That oral surgeons and dentists who submit claims other than dental claims shall use and all appropriate insuring entities shall accept the coding systems set forth in Sections 4.1.1. and 4.1.2. above.~~

~~4.3. All pharmacists shall use and all insuring entities shall accept the current version of the United States Food and Drug Administration's National Drug Code (NDC), or its successor, for claims for prescription drugs for which NDC codes exist.~~

~~§ 114-16-5. Practices Regarding Reimbursement of Claims and Explanation of Benefits~~

~~Practices regarding reimbursement of claims and explanation of~~

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~~benefits shall be left to the discretion of the insuring entity, depending upon the contractual agreements between the insurer and its insureds and/or participating provider network regarding deductibles, copayments, discounts and the like.~~

~~§ 114-16-6. Additional Information~~

~~Nothing in this rule shall be construed so as to prevent an insuring entity from requesting additional information directly from the insured or covered person, where such additional information is necessary for the determination of coverage or benefits applicable.~~

~~§ 114-16-7. Severability~~

~~If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provisions to other persons or circumstances shall not be affected thereby.~~

1 PATIENT CONTROL NUMBER		2		3		4 TYPE OF BILL	
5 BC-BE PROV NO.		6 FEDERAL TAX NO		7 MEDICARE NO		8 MEDICAID NO.	
9		10		11		12	
13		14		15		16	
17		18		19		20	
21		22		23		24	
25		26		27		28	
29		30		31		32	
33		34		35		36	
37		38		39		40	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
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97		98		99		100	

DUE FROM PATIENT

PROVIDER AND ADDRESS HERE

WEST VIRGINIA
DEPARTMENT OF HEALTH & HUMAN RESOURCES
TITLE XVIII (MEDICARE)
DEDUCTIBLE AND
COINSURANCE INVOICE
SEE REVERSE FOR INSTRUCTIONS

TRANSMISSION CODE 091		2A PROVIDER ID NO. (7)	2B PROVIDER (GROUP) ID NO. (7)		5 PRIMARY CARRIER CODE 1-NO OTHER CARRIER 2-MEDICARE 3-OTHER (SPECIFY NAME)		ENTR SELE
3 RECIPIENT'S LAST NAME FIRST			4 RECIPIENT'S ID NO. (11)		5 PRIMARY CARRIER INFORMATION. ENTER CODE. IF OTHER SPECIFY NAME HERE.		
6 TYPE OF COVERAGE CHECK ONE A <input type="checkbox"/> B <input type="checkbox"/>	7 PATIENT ACCOUNT NO. (10 MAX)	8 RECIPIENT'S H I B NUMBER (MEDICARE)		9 STATEMENT COVERS PERIOD FROM (M) YEAR TO (M) YEAR		10 MEDICAL PAID AMT	
1 DEDUCTIBLE AMOUNT	12 COINSURANCE AMT.	13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)		14 BLOOD DEDUCTIBLE AMT.		CARRIER CODE	

(The above form structure is repeated 10 times, with a large diagonal 'X' drawn across the entire page.)

CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

GROUP NO. CARDHOLDER I.D. NO. _____

CARDHOLDER NAME _____ LAST _____ FIRST _____ INITIAL _____ OTHER THIRD PARTY COVERAGE YES NO **FOR OFFICE USE ONLY**

PHARMACY INFORMATION

NAME _____ STREET NO. _____ CITY _____ STATE _____ ZIP _____

PHARM NO. _____ PHONE _____

RX NUMBER	NEW	VET	DATE	PRESCRIBER	DENT	DAM	DATE OF BIRTH				RELATIONSHIP TO CARDHOLDER				INGR. COST	DISP. FEE	TAX	TOTAL PRICE	DED. AMT	BAL.	
							MO	DAY	YR	M	F	CARDHOLDER	SPOUSE	CHILD							OTHER
1																					
2																					

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DO NOT WRITE
IN THIS SPACE**PHARMACY INVOICE**

Workers' Compensation Fund
P.O. Box 3151, Charleston, WV 25332



WV-401 Rev. 7-85

1. CLAIMANT NAME (Last, First, and Middle Names)		2. CLAIMANT ADDRESS (Street or PO Box, City, State, and Zip Code)	
EMPLOYER BUSINESS NAME		4. EMPLOYER MAILING ADDRESS	
CLAIMANT SOCIAL SECURITY NO.		6. DATE OF INJURY	7. CLAIM NO.
DIAGNOSIS CODE (ICD-9-CM)	9. PROVIDER NO.	10. CHECK HERE IF PAYMENT IS TO BE MADE TO CLAIMANT <input type="checkbox"/>	

PRESCRIPTION DETAIL

PRIOR AUTHORIZATION NO.	12. DATE WRITTEN	13. PRESCRIBING PHYSICIAN	14. PRESCRIBING PHYSICIAN'S PROVIDER NO.	15. PRESCRIPTION NO.
DATE FILLED	17. NATIONAL DRUG CODE	18. DRUG NAME		19. GENERIC <input type="checkbox"/> Yes <input type="checkbox"/> No
DRUG QUANTITY	21. EST. DAYS SUPPLY	22. REFILL <input type="checkbox"/> Yes <input type="checkbox"/> No	23. TOTAL CHARGE	24. AMOUNT PAID
BRAND NAME JUSTIFICATION				
CLAIMANT'S SIGNATURE		DATE	28. PHARMACIST'S SIGNATURE	DATE

PRIOR AUTHORIZATION NO.	12a. DATE WRITTEN	13a. PRESCRIBING PHYSICIAN	14a. PRESCRIBING PHYSICIAN'S PROVIDER NO.	15a. PRESCRIPTION NO.
DATE FILLED	17a. NATIONAL DRUG CODE	18a. DRUG NAME		19a. GENERIC <input type="checkbox"/> Yes <input type="checkbox"/> No
DRUG QUANTITY	21a. EST. DAYS SUPPLY	22a. REFILL <input type="checkbox"/> Yes <input type="checkbox"/> No	23a. TOTAL CHARGE	24a. AMOUNT PAID
BRAND NAME JUSTIFICATION				
CLAIMANT'S SIGNATURE		DATE	28a. PHARMACIST'S SIGNATURE	DATE

PRIOR AUTHORIZATION NO.	12b. DATE WRITTEN	13b. PRESCRIBING PHYSICIAN	14b. PRESCRIBING PHYSICIAN'S PROVIDER NO.	15b. PRESCRIPTION NO.
DATE FILLED	17b. NATIONAL DRUG CODE	18b. DRUG NAME		19b. GENERIC <input type="checkbox"/> Yes <input type="checkbox"/> No
DRUG QUANTITY	21b. EST. DAYS SUPPLY	22b. REFILL <input type="checkbox"/> Yes <input type="checkbox"/> No	23b. TOTAL CHARGE	24b. AMOUNT PAID
BRAND NAME JUSTIFICATION				
CLAIMANT'S SIGNATURE		DATE	28b. PHARMACIST'S SIGNATURE	DATE

Provided by statute, this is to certify that the medication(s) was provided as outlined above and that no other or additional charge for such medication(s) has been or will be against any person, firm, or corporation.

REMARKS	30. PROVIDER NAME AND ADDRESS
Page	

SERVICES INVOICE



DO NOT WRITE
IN THIS SPACE

- (D) Dental
- (N) Nursing Home
- (P) Practitioner
- (R) Vocational Rehabilitation
- (V) Other Medical Vendor

Workers' Compensation Fund
P.O. Box 1151, Charleston, WV 25332

WC-400 Rev. 6-87

1. CLAIMANT NAME (Last, First, and Middle Names)			2. CLAIMANT ADDRESS (Street or PO Box, City, State, and Zip Code)				
EMPLOYER BUSINESS NAME			4. EMPLOYER MAILING ADDRESS				
CLAIMANT SOCIAL SECURITY NO.			6. DATE OF INJURY		7. CLAIM NO.		
REFERRING PHYSICIAN'S PROVIDER NO.		9. REFERRING PHYSICIAN'S NAME		10. DATE CLAIMANT FIRST CONSULTED PROVIDER FOR THIS CONDITION			
DIAGNOSIS CODE (ICD-9-CM)/DESCRIPTION							
1.							
2.							
3.							
PRIOR AUTHORIZATION NO.		13. IF EMERGENCY CHECK HERE <input type="checkbox"/>	14. PATIENT ACCOUNT NO.		15. PROVIDER NO.		
CHECK HERE IF PAYMENT IS TO BE MADE TO CLAIMANT <input type="checkbox"/>		17. PAYEE NO.		18. PAYEE NAME AND ADDRESS			
SERVICE DATE	20. PROCEDURE CODE	21. MOD CODE	22. DESCRIPTION	23. CHARGES	24. UNITS	25. T.O.S.	26. DENTAL TOOTH NO.
PROVIDER OR CLAIMANT SIGNATURE			DATE	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE	
REMARKS				32. PROVIDER NAME, ADDRESS AND TELEPHONE NO.			

