

WEST VIRGINIA

SECRETARY OF STATE

KEN HECHLER

ADMINISTRATIVE LAW DIVISION

Form #3

RECEIVED

1992 SEP 18 PM 4: 13

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY West Virginia Code §§ 33-2-10 and 33-15B-3

AMENDMENT TO AN EXISTING RULE: YES NO

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: Series 16

TITLE OF RULE BEING PROPOSED: Standards for Uniform Health
Care Administration

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.



Hanley C. Clark
Insurance Commissioner

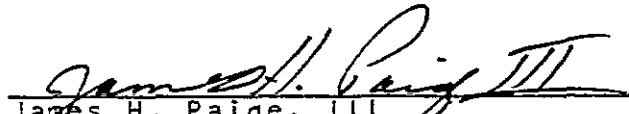
6.20

CONSENT TO PROPOSAL OF RULE

To Whom It May Concern:

Pursuant to West Virginia Code § 5F-2-2(a)(12), the undersigned hereby grants consent to the proposal of the following rule proposed by the Insurance Commissioner of the State of West Virginia: Title 114, Series 16, relating to Standards for Uniform Health Care Administration.

Dated this 30 day of July, 1992.


James H. Paige, III
Secretary of Tax and Revenue

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
2019 Washington Street, East,
Charleston, WV 25305-0540

	ANNUAL		FISCAL YEAR	
1. Effect of Proposed Rule	Increase	Decrease	Current	Next Thereafter
Estimated Total Cost	NONE			
Personal Services				
Current Expense				
Repairs & Alterations	NONE			
Equipment				
Other				

2. Explanation of above estimates:

The proposed rule will have no fiscal impact on state, local, or federal government.

3. Objectives of these rules:

The objective of this rule is to establish the acceptance and use throughout the health care system of standard administrative forms, terms, and procedures. It requires that all insurers, third-party administrators, and health care providers implement and use such standards in a uniform manner.

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.

Implementation of this rule should decrease health care costs by increasing administrative efficiency in the health care system.

Date: Aug. 7, 1992

Signature of Agency Head or Authorized Representative

Hanley C. Clark

Hanley C. Clark
Insurance Commissioner

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER

DATE: SEPTEMBER 18, 1992

LEGISLATIVE RULE TITLE: Standards for Uniform Health Care
Administration (Title 114, Series 16)

DESCRIPTION OF RULE

This proposed rule implements 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. Requirements regarding standardized forms, coding and terminology, and practices regarding reimbursement of claims and explanation of benefits established in the rule apply to all health care providers, third-party payors, all applicable state agencies and departments, and all insurers in the State.

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER

DATE: SEPTEMBER 18, 1992

LEGISLATIVE RULE TITLE: Standards for Uniform Health Care Administration (Title 114, Series 16)

1. Authorizing statute(s) citation West Virginia Code
§§ 33-2-10 and 33-15B-3
2. a. Date filed in State Register with Notice of Hearing:
August 10, 1992
- b. What other notice, including advertising, did you give of the hearing?
None
- c. Date of hearing(s): The public comment period ended on September 11, 1992 at 4:30 p.m.
- d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.
Attached XX No comments received _____
- e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)
September 18, 1992
- f. Name and phone number of agency person to contact for additional information:
Linda Gay
Associate Counsel
(304) 558-0401

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

_____ Not applicable _____

b. Date of hearing: Not applicable

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

_____ Not applicable _____

d. Attach findings and determinations and reasons:

Attached Not applicable

TITLE 114
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. Separability
-
- 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. WVMMS-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. WVMMS-111 Form for Dental Claims Submitted to Medicaid

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 16
STANDARDS FOR UNIFORM HEALTH CARE ADMINISTRATION

§ 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. --

1.4. Effective Date. --

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, 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

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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; any 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 maintenance organization organized in accordance with the provisions of Article 25A, Chapter 33 of the West Virginia Code; any health care corporation organized in accordance with Article 25, 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 be submitted on the current WVMMS-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.

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Title 114, Series 16

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

3.4.c. 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.a. and 4.1.b. 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.a. The current International Classification of Diseases (ICD-9-CM) codes developed by the World Health Organization, or their successors; and

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4.1.b. 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.a. and 4.1.b. 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 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.

§ 114-33-6. 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. Separability

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.

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		CHAMPLUS <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (VA File #)		GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)		FECA BLK LUNG <input type="checkbox"/> (SSN)		OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)							
CITY				STATE				8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY				STATE			
ZIP CODE				TELEPHONE (include Area Code)				Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				ZIP CODE				TELEPHONE (INCLUDE AREA CODE)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:						11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO						b. EMPLOYER'S NAME OR SCHOOL NAME							
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME							
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d.							

PATIENT AND INSURED INFORMATION

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO \$ CHARGES

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. _____

2. _____

3. _____

4. _____

24. A		B		C		D		E		F		G		H		I		J		K			
DATE(S) OF SERVICE From		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OP=HOPCS I=MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS EPSCD OR (Family Plan)		EMG		CCS		RESERVED FOR LOCAL USE					
MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. 8275, 899 back) YES NO

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SIGNED _____ DATE _____

P.N.# _____

4 TYPE OF BILL

5 BCBS PROV NO.

6 FEDERAL TAX NO

7 MEDIGARE NO

8 MEDICARD NO

9

10 PATIENT'S LAST NAME

11 FIRST NAME

12 PATIENT'S ADDRESS

13 CITY

14 STATE

15 ZIP

16 BIRTH DATE

17 SEX

18 ADMISSION DATE

19 ADMISSION TIME

20 DISCHARGE DATE

21 STATEMENT FROM

22 STATEMENT COVERS PERIOD FROM

23 COVID

24 COVID

25 COVID

26 COVID

27 OCCURRENCE DATE

28 OCCURRENCE CC

29 OCCURRENCE DATE

30 OCCURRENCE CC

31 OCCURRENCE DATE

32 OCCURRENCE CC

33 OCCURRENCE DATE

34 OCCURRENCE CC

35 OCCURRENCE DATE

36 OCCURRENCE CC

37 OCCURRENCE FROM

38 OCCURRENCE THROUGH

39

CONDITION CODES

BLOOD RECORD (PINTS)

40 SP

41 SG

42

43

44

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50

51

52

53

54

55

56

57

58

59

60

61

62

63 DESCRIPTION

64 ICD CODE

65 ICD CODE

66 ICD CODE

67 ICD CODE

68 ICD CODE

69 ICD CODE

70 ICD CODE

71 ICD CODE

72 ICD CODE

73 ICD CODE

74 ICD CODE

75 ICD CODE

76 ICD CODE

77 ICD CODE

78 PAYER

79 INCL SW AGG

80 DEDUCT BLE

81 COINSURANCE

82 EST RESIDENCE

83 OR PARMENT

84 EST AMOUNT DUE

DUE FROM PATIENT

85 MEMBER NAME

86 SEC ID

87 RES ID

88 PHONE

89 INSURANCE

90 ENDORSE

91 EMP ID

92 EMPLOYEE NAME

93 EMP ID

94 EMP ID

95 TRAUMA AND OTHER DIAGNOSES DESCR

96 OTHER DIAGNOSES CODES

97 ICD CODE

98 ICD CODE

99 ICD CODE

100 ICD CODE

101 ICD CODE

102 ICD CODE

103 ICD CODE

104 ICD CODE

105 ICD CODE

106

107

X

PROVIDER
NAME AND ADDRESS HERE

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

5 PRIMARY CARRIER CODE 1-NO OTHER CARRIER 2-MEDICARE 3-OTHER (SPECIFY NAME)	ENTER BELOW
---	-------------

1 TRANSMISSION CODE 091	2A PROVIDER ID NO. (7)	2B PROVIDER (GROUP) ID NO. (7)	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 B	7 PATIENT ACCOUNT NO. (10 MAX)	8 RECIPIENT'S H I B NUMBER (MEDICARE)	9 NO DAY MONTH YEAR	10 MEDICARE PAID AMT	11 DEDUCTIBLE AMOUNT
12 COINSURANCE AMT	13 COVERED BY PRIMARY CARRIER OTHER THAN TITLE XVIII (MEDICARE)	14 BLOOD DEDUCTIBLE AMT.	CARRIER CODE		

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CARRIER CODE		

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CARRIER CODE		

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

GROUP NO. <input type="checkbox"/>	CARDHOLDER ID NO.	OTHER THIRD PARTY COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		FOR OFFICE USE ONLY						
CARD NUMBER	LAST	FIRST	INITIAL	MO	DAY	YR	M	F	RELATIONSHIP TO CARDHOLDER	
PHARMACY INFORMATION			PARENT LAST NAME	FIRST INITIAL	DATE OF BIRTH		RELATIONSHIP TO CARDHOLDER			
NAME					MO	DAY	YR	M	F	CARDHOLDER SPOUSE CHILD OTHER
ADDRESS									INCR	
CITY									OCST	
STATE									DISP	
ZIP									FREE	
PHONE									TAX	
PHARMACY									TOTAL	
NO.									PRICE	
PRESCRIPTION	NEW	REFILL	DATE	TIME	PHARMACY	PRESCRIPTION	PERCENT	DATE	DEDUCT	
									AMT	
									BAL	

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SERVICES INVOICE



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

DO NOT WRITE
IN THIS SPACE

WC-400 Rev. 6-87

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

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

Attachment to Question 2(d):

The Department received only one comment regarding the proposed regulation. This comment was sent by Wayne Boggess, R. Ph., Account Manager for First Health Services Corporation. A copy of the comment is attached hereto and incorporated herein by reference.

After reviewing the comment, the Department concluded that an amendment to the proposed rule would be appropriate. The amendment concerns Section 3.3 which requires an insuring entity, other than Workers' Compensation and Medicaid, to accept the universal pharmacy claim form approved by the National Council for Prescription Drug Programs. First Health explained that some insuring entities, such as the Public Employees Insurance Agency, currently require their participating pharmacists to transmit claims information at "point-of-sale," i.e., via electronic transmission. "Point-of-sale" transmission increases administrative efficiency and allows the pharmacist to screen for possible adverse drug interaction. Since mandating the acceptance of the universal pharmacy claim form would decrease efficiency in this case, the Department is amending the proposed rule to allow insuring entities to require their participating pharmacists to submit claims at "point-of-sale."

FIRST HEALTH SERVICES CORPORATION

1002 Kanawha Valley Building
300 Capitol Street
Charleston, WV 25301

September 11, 1992

B. Keith Huffman, General Counsel
Office of the Insurance Commissioner
P.O. Box 50540
2019 Washington Street, East
Charleston, WV 25305-0540

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LEGAL DIVISION
W. VA. INS. DEPT.

Dear Mr. Huffman:

The following comments are submitted regarding Title 114, Legislative Rule, Insurance Commissioner, Series 16: "Standards for Uniform Health Care Administration."

Paragraph 3.3 : This paragraph would seem to require insurers and third party administrators to accept the pharmacy universal claim form (UCF) even when electronic claims submission is required for provider participation in a drug program. Point-of-sale submission of drug claims is now a requirement in the West Virginia PEIA Prescription Drug Program, as well as other commercial drug programs. This system allows the insurer, through its claims administrators, to review each claim for proper deductible, copayment, and allowed charges at the time of prescription filling. The system prevents overcharges to members and insurers due to a pharmacy's lack of deductible history, copayment or allowed charge information.

Paragraph 3.5 allows voluntary arrangements between insurers and providers for point of sale transactions, but the foundation of a prospective drug utilization review program, as required by the PEIA Prescription Drug Program, Medicaid drug programs, and other commercial drug programs is a mandatory electronic claims submission requirement for providers. Although repealed, the Medicare Catastrophic Coverage Act of 1988 included provisions for a point of sale prospective drug utilization review program. Without mandatory point of sale submissions, providers and members will not know of claim denials until after the prescription is filled and the paper claim adjudicated. Deterrents to drug abuse in the way of early refill or duplicate claims denials would be defeated. Point of sale technology provides each pharmacy filling prescriptions for a member access to the third party administrator's database of drug utilization history for that member. Because the point of sale claims submission is mandatory, that history is current and complete.

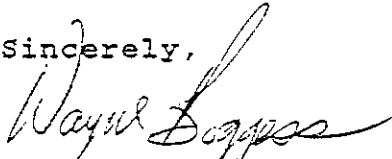
Mr. B. Keith Huffman, General Counsel
September 11, 1992
Page 2

Mandatory point of sale claims submission allows the third party administrator to review information from all pharmacies submitting claims for a member and screen for possible adverse drug interactions. The TPA's prospective drug utilization review software can then alert the pharmacist of any potential early refills, duplicate claims, drug-drug interactions, drug-pregnancy interactions, overutilization, underutilization, or therapeutic duplications from all pharmacies dispensing to that patient. Point of sale technology allows the pharmacist to be alerted before the prescription is filled, thereby avoiding potential adverse drug reactions. Requiring insurers and third party administrators to accept the UCF if providers choose not to submit claims electronically would limit the effectiveness of prospective drug utilization review. The pharmacist at one drug store would not be aware of prescriptions filled at another.

The PEIA Prescription Drug Program has worked well over a year now with mandatory point of sale provisions. The program is well accepted by both providers and members. The West Virginia Medicaid drug program recently implemented point of sale claims processing and is enjoying equal success.

I would also like to point out a deficiency of the present Universal Claim Form. The only field available for pharmacists to use in submitting copayment or deductible information is the "DED AMT" field. Many drug programs, like PEIA's, require submission of exact deductible, copayment, and usual and customary charges for drug claim adjudication. The present NCPDP universal drug claim form is not capable of reporting all these data elements and does not enjoy a true universal application to all drug programs. This is an issue for NCPDP to review, and might perhaps be addressed better on a future UCF.

Sincerely,



Wayne Boggess, R.Ph.
Account Manager
WV-PEIA Prescription Drug Program



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

GASTON CAPERTON
Governor

HANLEY C. CLARK
Insurance Commissioner

September 18, 1992

HAND DELIVERED

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

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1992 SEP 18 PM 4:13
OFFICE OF THE INSURANCE
COMMISSIONER

Dear Ms. Cooper:

Enclosed please find for filing: the "Notice of Agency Approval of a Proposed Rule and Filing with the Legislative Rule-Making Review Committee;" the "Description of Rule;" the "Legislative Rule-Making Review Committee Questionnaire;" a copy of the agency-approved rule entitled "Standards for Uniform Health Care Administration" for Series 16, Title 114; and a copy of the Insurance Commissioners's existing rule entitled "Uniform Health Care Claim Forms," which is to be replaced by the aforementioned agency-approved rule.

Very truly yours,

Linda Gay
Linda Gay
Associate Counsel

LG/fs
Enclosures