Vermont Department of Banking, Insurance, Securities and Health Care Administration

Rule No. H-2008-04

Health Insurance Claims Administration Rule

Section 1. Purpose and Goals.

(a) The purpose of this Rule is to establish a process for the creation of uniform standards, including electronic transaction standards, for health insurance claims administration and adjudication, including but not limited to standards relating to claims forms, patient invoices and explanation of benefits forms, the use of payment codes, claims submission and processing procedures, and the prior authorization process.

(b) The goals of this Rule are set forth in 18 V.S.A. § 9408 and Sec. 55 of Act 191 (2006): (1) simplifying the claims administration process for consumers, health care providers, and others so that the process is more understandable and less time-consuming; and (2) lowering administrative costs in the health care financing system.

Section 2. Authority.

This Rule is adopted pursuant to the authority vested in the Commissioner by law, including but not limited to 18 V.S.A. § 9408, 8 V.S.A. § 15(a), 18 V.S.A. § 9404, and Sec. 55 of Act 191 (2006).

Section 3. Applicability and Scope

(a) This Rule applies to health claims, health encounters, electronic data interchange between Health Insurers and Health Care Providers, and to any other matter relating to claims administration and adjudication.

(b) Except as otherwise specifically provided, the requirements of this Rule apply to all Health Insurers and Health Care Providers.

(c) This Rule does not prohibit a Health Insurer from requesting additional information required to determine eligibility of a claim under the terms of the policy or certificate issued to the claimant, unless such request is inconsistent with state or federal law, or with a provision of this Rule or any other applicable rule, or with the standards adopted hereunder.

(d) This Rule does not prohibit a Health Insurer or Health Care Provider from using alternative forms or procedures specified in a written contract between the Health Insurer and Health Care Provider, unless such use is inconsistent with state or federal law, or with a provision of this Rule or any other applicable rule, or with the standards adopted hereunder.

(e) This Rule does not exempt a Health Insurer or Health Care Provider from any data reporting requirements under state or federal law or regulation.

(f) In the event of a conflict between the requirements of this Rule and federal law or regulation, the requirements of federal law or regulation, including but not limited to the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, shall prevail.

(g) Unless expressly included in a standard adopted or incorporated by reference in this Rule, the requirements of this Rule shall not apply to long term care insurance policies, disability policies, accident indemnity or expense policies, student indemnity and expense policies, stand alone dental policies, or supplemental hospital indemnity or specified disease indemnity policies.

(h) This Rule shall not apply to Health Care Providers located outside of this state except in the following manner: a Health Insurer shall include the standards adopted or incorporated by reference by this Rule as conditions of contracting between the Health Insurer or its contracted agent(s) and the out of state Health Care Provider, provided that such standards shall not apply to Health Care Providers, as defined in Section 4 (3) (A), located outside this state, that has fewer than 1000 inpatient discharges during the prior calendar year and such standards shall not apply to Health Care Providers, as defined in Section 4 (3) (B)whose total dollar charges for services to Vermont residents is less than 25 percent of its total charges during the prior calendar year, unless a different applicability threshold is expressly included in a standard adopted or incorporated by reference in this Rule.

(i) This Rule shall not apply to Health Insurers with less than five percent of the insured market in Vermont, and to third party administrators with fewer than 5,000 covered lives in Vermont, with respect to any market to which the standard applies, unless a different applicability threshold is expressly included in a standard adopted or incorporated by reference in this Rule.

Section 4. Definitions.

As used in this Rule:

(1) “Commissioner” means the Commissioner of the Department.

(2) “Department” means the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

(3) “Health Care Provider” means:

(A) all institutions engaged in claims administration or claims adjudication activities with a Health Insurer, whether public or private, proprietary or nonprofit, which offer diagnosis, treatment, inpatient or ambulatory care to two or more unrelated persons, and the buildings in which

those services are offered. The term shall not apply to any facility operated by religious groups relying solely on spiritual means through prayer or healing, but includes all institutions included in subdivision 9432(7) of Title 18, except health maintenance organizations;

(B) a person, partnership or corporation engaged in claims administration or claims adjudication activities with a Health Insurer, other than a facility or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment or confinement; and

(C) any agent or affiliate of an institution or entity or person identified in subdivisions (A) and (B) of this subdivision (3), including billing agents or other billing contractors of such institutions or entities.

(4) "Health Claim" means a health care claim for reimbursement or approval or any other transaction related to a health claim between a Health Care Provider and a Health Insurer.

(5) "Health Insurer" means:

(A) any health insurance company, nonprofit hospital or medical services corporation, or health maintenance organization transacting health insurance business in Vermont. The requirements of this Rule shall apply to:

(i) any Health Insurer in connection with its insured plans;

(ii) any Health Insurer, or the controlled affiliate of a Health Insurer, acting as a third-party administrator for an insured or non-insured health benefit plan;

(iii) any agents or affiliates of the Health Insurer who contract to administer the benefits covered or administered by the Health Insurer, such as pharmacy benefit managers, radiology benefit managers, and mental health services review agents licensed under 8 V.S.A. § 4089a; and

(iv) any third party administrator that pays for, reimburses, or administers the payment or reimbursement of health care expenses on behalf of an insured or non-insured health benefit plan in Vermont, including any entity that pays for, reimburses, or administers the payment or reimbursement of health care expenses on behalf of the employee health benefit plan offered by the State of Vermont, and the employee health benefit plan offered by any agency or instrumentality of the state; and

(B) Medicaid, VHAP, SCHIP and any other health benefit plan offered or administered by the Vermont Office of Health Access, to the extent permitted by federal law or federal authority, and to the extent not inconsistent

with state budget policy as expressly stated and enacted in an annual appropriations act.

(6) "Rule" means the administrative rule adopted herein.

Section 5. Establishment of the Vermont Claims Administration Collaborative

(a)(1) The Commissioner shall contract with the Vermont Program for Quality in Health Care, Inc. ("VPQHC"), or some other suitable contractor designated by the Commissioner, to facilitate and provide administrative support for a claims administration initiative to be established, implemented, and known as the Vermont Claims Administration Collaborative.

(2) The Vermont Claims Administration Collaborative shall be an entity consisting of members approved by the Commissioner who represent hospitals, health care professionals, Health Insurers, group and individual purchasers and consumers, and the Department. Members may appoint one or more designees from time to time to participate in the Collaborative.

(3) The Collaborative shall recommend measures designed to improve administrative efficiencies, to lower transaction costs (recognizing that an initial investment may be necessary at times to achieve these goals), to simplify the claims administration and adjudication process, and to develop standards for the submission and processing of claims.

(4) The Commissioner or the Commissioner's designee, shall be a member of the Collaborative. The Commissioner shall appoint a Chair of the Collaborative. The Commissioner, in consultation with the members of the Collaborative, shall establish rules of procedure for the Collaborative, including membership eligibility rules and anti-trust guidelines.

(b) On or about January 1 of each year, the Commissioner or the Commissioner's designee, after consultation with the members of the Vermont Claims Administration Collaborative, shall establish an annual agenda for the Collaborative. The Vermont Claims Administration Collaborative shall make recommendations to the Commissioner for the adoption by the Commissioner of claims administration and adjudication standards pursuant to the administrative rule-making process. The Commissioner may adopt the recommended standard with or without amendment, provided that if the Commissioner proposes to amend the standard recommended by the Collaborative, the Commissioner shall request the Collaborative to consider the amendment before the standard is filed as a proposed administrative rule with the Secretary of State under 3 V.S.A. section 838. Notwithstanding the inability of the Collaborative to agree upon a recommendation with respect to a standard included in the annual agenda, the Commissioner may amend or

adopt a rule to include such a standard. The Commissioner's authority to adopt rules as set forth in this Rule is in addition to any other rule-making authority established by law.

(c) In developing standards for the Commissioner, the Vermont Claims Administration Collaborative shall consult with national standard setting entities including but not limited to Centers for Medicare and Medicaid Services (CMS), the National Uniform Claim Form Committee, the American National Standards Institute, the Council for Affordable Quality Healthcare's ("CAQH") Committee on Operating Rule Exchange ("CORE") and the National Uniform Billing Committee.

(d) Standards developed by the Vermont Claims Administration Collaborative shall not be required for use by Health Insurers and Health Care Providers until adopted by the Commissioner by rule. The Collaborative and the Commissioner shall give due consideration to the budget cycles and other implementation issues of Health Insurers and Health Care Providers in establishing an effective date for any adopted standard.

(e) Health Insurers shall accept the applicable electronic data if transmitted in accordance with the adopted electronic data interchange claims administration standard. Health Insurers may reject electronic data if not transmitted in accordance with the adopted electronic data interchange claims administration standard.

Section 6. Claims Administration and Adjudication Standards

The following claims administration and adjudication standards are hereby adopted by the Commissioner. Where standards are adopted and incorporated by reference, such standards are available for inspection and review at the Department's website: www.bishca.state.vt.us

(1) Standards for Explanations of Benefits (EOBs)

(A) A sample EOB is provided. Health Insurers that adopt this format will be in compliance with this rule. Health Insurers shall maximize the visual clarity of the EOB to achieve optimum readability and be consistent with H-2009-03 or any subsequent replacement Rule(s). The font size should be as large as possible. EOBs adopted by Health Insurers with other formats, additions to the minimum required elements or enhancement of the terms and definitions, which are found by the Commissioner to be confusing to the general public or do not adequately provide for visual clarity, may be subject to review and disapproval with or without conditions by the Department.

EOB Formats

1. Health Insurers shall retain discretion to determine the design format of their EOB forms, including but not limited to the paper size, page layout, and the order in which the required minimum set of elements appear on the page.

2. Company branding and logos can be individualized and placed anywhere on the EOB.

3. The size of the page used to print EOBs is at the discretion of the health insurer.

(B) EOB Minimum Required Elements

All EOBs shall include the following minimum set of required elements.

1. Service Provider

2. Date of Service

3. Type of Service
(Includes as a minimum, inpatient, outpatient, office visit, and pharmacy or a detailed description of the service rendered)

4. Billed Charges

5. Not Covered/Not Allowed:
with subcategories of Not Due From Patient and Due From Patient

6. Allowed Amount

7. Other Insurance Payments

8. Co-Pay

9. Deductible

10. Deductible Met to Date

11. Co-insurance

12. Amount Paid by Plan

13. Total Due from Patient

14. Reason Code and accompanying explanations. Reason codes and definitions of those are either the standard HIPAA reason codes or specific to the insurer.

15. Member Service telephone number

(C) EOB Terms and Definitions

Each EOB shall be accompanied by an explanation of the terms utilized on the EOB, either as a separate page or on the reverse side of the EOB.

	Required Term	Required Minimum Definition
1.	Service Provider	The provider who billed your plan for the service.
2.	Date of Service	The date you received the services recorded on the statement.
3.	Type of Service	No definition required
4.	Billed Charges	Amount billed for the service
5.	Not Covered	Any billed charges not covered by your policy including services provided by an out-of-network or non-participating provider.

6.	Not Allowed your plan.	An adjustment made by
7.	Not Due From Patient	No definition required
8.	Due from Patient	No definition required
9.	Allowed Amount	The amount your plan will allow for this service
10.	Other Insurance Payments	Any payment made by another policy that covers you.
11.	Co-Pay	The fixed dollar amount you are required to pay your service provider for this service.
12.	Deductible	An amount you must pay toward the cost of services each Plan year before your Plan pays any benefit
13.	Deductible Met to Date	No definition required
14.	Co-insurance	The percentage of the allowed amount(s) that you are required to pay your provider.
15.	Amount Paid by Plan	No definition required
16.	Total Due from Patient	The amount the provider may bill you.
17.	Reason Code	A code that provides additional information.

(D) The EOB shall account for all applicable contract benefits, including out-of-pocket requirements and contracted provider

discounts, against each billed charge for each service on the EOB. The EOB will clearly show the amount owed by the member to the provider, if any, for each service on the EOB and be mathematically accurate. EOBs shall be sent to the consumer within the payment guidelines of 18 V.S.A. §9418.

(E) Implementation Date. This standard shall be fully implemented by all Health Insurers on or of before Oct 1, 2010.

(F) Member Satisfaction. Each Health Insurer shall be required to track member satisfaction with the Health Insurer's EOB. This may be accomplished by query of their internal phone tracking system or by survey, and shall be performed every other year. A baseline measurement of member satisfaction shall occur no later than April 1, 2011. Results and recommended changes shall be made available to VCAC within forty-five days of completion of the query or survey.

(G) Office of Vermont Health Access (OVHA). OVHA shall be excluded from the requirements of this Section (1), Standards for EOBs, for Medicaid beneficiaries.

(2) Standards for Patient Bills

(A) Sample Patient Bills are provided. Hospitals, Federally-Qualified Health Centers (FQHCs), Providers and Billing Service Providers (hereinafter "Billing Entities") that adopt this format will be in compliance with this rule. Billing Entities shall maximize the visual clarity of Patient Bills to achieve optimum readability and be consistent with H-2009-03 or any subsequent replacement Rule(s). The font size should be as large as possible. Patient Bills adopted by Billing Entities with other formats, additions to the minimum required elements or enhancement of the terms and definitions, which are found by the Commissioner to be confusing to the general public or do not adequately provide for visual clarity, may be subject to review and disapproval with or without conditions by the Department.

(B) Patient Bill Formats

1. Billing Entities shall retain discretion to determine the design format of their Patient Bill forms, including but

not limited to the paper size, page layout, and the order in which the required minimum set of elements appear on the page. However, the minimum set of elements must appear in an order, which provides for mathematical ease in determining the amount due from the Patient.

2. Billing Entities' branding and logos can be individualized and placed anywhere on the Patient Bills.

(C) Patient Bills Minimum Required Elements. All patient bills shall include the following minimum set of required elements:

1. Service Provider

2. Date of Service

3. Type of Service (Includes as a minimum, inpatient, outpatient, office visit, and pharmacy or a detailed description of the service rendered)

4. Billed Charges

5. Amount Paid by Plan

6. Plan Adjustments

7. Patient Payments

8. Due from Patient

9. When a past due amount has been referred to collection, the bill must include a statement indicating whether the amount due from the patient includes or excludes the amount referred to collection.

10. A statement that additional detail is available upon request.

(D) Patient Bills Terms and Definitions. Each Patient Bill shall be accompanied by an explanation of the terms utilized on the Patient Bills, either as a separate page or on the reverse side of

the Patient Bills. Billing Entities may add to the required minimum definitions.

	Required Term	Required Minimum Definition
1.	Service Provider	The provider who billed your plan for the service.
2.	Date of Service	The date you received the services recorded on this bill.
3.	Type of Service	No definition required
4.	Billed Charges	Amount billed for the service
5.	Amount Paid by Plan	No definition required
6.	Adjustments	The amount that your provider and/or your plan have agreed to discount from the billed charge.
7.	Patient Payments	The dollar amount you have paid
8.	Due from Patient	No definition required

(E) Generation of Patient Bills.

1. Bills shall be generated when payment is due from the patient for a new service, a past due balance, or both.
2. The Minimum Required Elements shall appear on the Patient Bills for any new service that has been provided.
3. Any unpaid balance for prior services shall appear on the bill.

4. Billing Entities that on the effective date of the Rule, bill separately for professional and institutional services or bill for each encounter may continue to do so.

(F) Implementation Date. This standard shall be fully implemented in two stages. All Hospitals, FQHCs and provider practices with three or more licensed health care practitioners shall implement these standards on or before January 1, 2011. All other providers shall implement these standards on or before July 1, 2011. The Department may grant a waiver to extend the implementation deadline, on an individual basis, if a provider or facility is not reasonably able to implement the requirements within the specified timeframe.

(3) Standards for Member Identification Cards (ID Cards)

(A) Applicability

1. These standards shall apply to all health insurers for medical and mental health services, with the exception of specific policies referenced in this Rule H-2008-04, and dental and vision policies.

2. The standards shall also apply to health benefit plans offered or administered by the Office of Vermont Health Access (OVHA), with the exception of effective date, group or account number, and co-pay elements.

3. ID Cards issued by insurers for medical and mental health services, and health benefit plans administered by OVHA, shall comply with Health Insurance Portability and Accountability Act of 1996's ID Card requirements or any other related federal or state regulation.

(B) Minimum Required ID Card Elements

All ID cards shall include the set of required elements shown below. Health insurers may enhance ID Cards by including additional elements or information to the required set of elements listed below, at their discretion.

1. Member name

2. Member identification number

3. Effective date (date of current policy, most recent change to the policy or anniversary date of the group, as appropriate to each health insurer)

4. Group or account number

5. Payer billing address

6. Customer service telephone number and other phone numbers as appropriate to facilitate provision of care (e.g. pharmacy benefits, pre-certification, mental health/substance abuse)

7. Visit co-payments are required, when contractually applicable, for at least primary care office visits, specialist office visits and hospital emergency room visits.

(C) Effective Date

These ID Card requirements shall be effective upon policy renewal, or upon any request for an ID Card replacement, on or after April 1, 2010.

(4) Standards for Mid Level Practitioner Billing:

Health Insurers shall accept claims submitted directly by Physician Assistants or Nurse Practitioners who are billing within the scope of their licensure or certification. All Health Insurers shall implement this procedure on or before July 1, 2010.

(5) Standards for Web-Based Prior Approval:

(A) These requirements shall apply to all services for which a Health Insurer requires Prior Approval.

(B) Providers are required to use the web-based system to request prior authorizations, however the insurer shall maintain a parallel backup system for providers that do not have an adequate infrastructure for access to web-based prior authorization systems.

(C) Health Insurers shall provide 24-hour turn around time for entry of decisions into its claim processing system.

(D) Health Insurers shall provide the Department of Banking, Insurance, Securities and Health Care Administration on a yearly basis, beginning July 1 2011, with the percentage of prior approvals completed utilizing their web- based prior approval systems

(F) Implementation date: January 1, 2011. The Department may grant a waiver to extend the implementation deadline, on an individual basis, if a Health Insurer is not reasonably able to implement the requirements within the specified timeframe.

Section 7. Enforcement

The Commissioner may enforce a violation of a provision of this Rule in accordance with 18 V.S.A. section 9412, 8 V.S.A. section 3661, and any other enforcement authority conferred on the Commissioner by law.

Section 8. Amendment of Regulation 93-4.

BISHCA Regulation 93-4, "Uniform Claim Forms and Uniform Standards and Procedures for Processing" will be amended as Section 6 standards are adopted.

Section 9. Effective date.

This Rule shall take effect on April 21, 2009.

Previously amended effective February 1, 2010.

Amended effective April 1, 2010