REPORT OF THE
STATE CORPORATION COMMISSION'S
BUREAU OF INSURANCE ON

# The Feasibility of Creating A Universal Health Insurance Claims Form

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

# HOUSE DOCUMENT NO. 7

COMMONWEALTH OF VIRGINIA
RICHMOND
1993

PRESTON C. SHANNON
CHAIRMAN

THEODORE V. MORRISON, JR.
COMMISSIONER

HULLIHEN WILLIAMS MOORE
COMMISSIONER

COMMONWEALTH OF VIRGINIA

WILLIAM J. BRIDGE
CLERK OF THE COMMISSION
P. O. BOX 1197
RICHMOND, VIRGINIA 23209-

**STATE CORPORATION COMMISSION**

October 16, 1992

TO: The Honorable L. Douglas Wilder
Governor of Virginia
and
The General Assembly of Virginia

We are pleased to transmit this Report of the the State Corporation Commission's Bureau of Insurance on The Feasibility of Creating a Universal Health Insurance Claims Form.

The study was initiated and the report prepared pursuant to House Joint Resolution 241 of the 1992 Session of the General Assembly of Virginia.

Respectfully submitted,

Preston C. Shannon
Chairman

Theodore V. Morrison, Jr.
Commissioner

Hullihen Williams Moore
Commissioner

# Table of Contents

## EXECUTIVE SUMMARY

The State Corporation Commission's Bureau of Insurance was requested by the 1992 General Assembly, pursuant to House Joint Resolution No. 241 (see Appendix A), to study the feasibility of creating a universal health insurance claims form for use by all insurance carriers licensed in the Commonwealth. The study was requested because (i) various and multiple claims forms which request duplicative and diverse information are a factor in administrative costs; (ii) completing these varying health insurance claims forms requires providers to have separate staff whose sole duty is to act as liaison for consumers and insurance carriers; and (iii) the dollars spent on administering health care could be more efficiently and effectively utilized on the provision and delivery of health care.

The Bureau surveyed the top twenty-five (25) writers of accident and sickness insurance policies in Virginia to determine whether they would be in favor of the creation of a single health insurance claims form. Out of nineteen (19) responses received, twelve (12) companies said they would be in favor of this proposal. Although the survey did not ask the respondents to comment on a particular form, several companies mentioned on the survey that they would not be opposed to the establishment of a universal claims form as long as it was the HCFA-1500 for providers and the UB-82 for hospitals (see Appendix B). These are national forms that were developed by the Uniform Claims Form Task Force and the National Uniform Billing Committee. The Health Care Financing Administration co-chaired both of these groups together with the American Medical Association and the American Hospital Association, respectively. One company stated that the development, implementation, and required use of uniform claims forms could best be achieved by using the forms already developed at the federal level. Several other companies stated that they would be opposed to any form that was unique to Virginia.

The Bureau also surveyed one hundred (100) randomly selected physicians licensed and living in Virginia to determine whether they would be in favor of the development of a single health insurance claims form. Out of thirty (30) responses received, twenty-eight (28) said they would be in favor of such a proposal. Although the survey did not ask the respondents to comment on a particular form, several physicians stated that the HCFA-1500 is currently being used as a national form.

Eighteen (18) advisory organizations representing provider groups other than physicians were also surveyed. Out of sixteen (16) responses received, fifteen (15) indicated that they would be in favor of the creation of a universal claims form for health insurance. Several organizations mentioned the HCFA-1500 and the UB-82 claims forms.

The Bureau also researched the activities of the other states to determine whether any other states had adopted a standard health insurance claims form. Twenty-six (26) states have either adopted a standard claims form or are considering it. Thirteen (13) of these states either require or plan to require insurers to accept the HCFA-1500 claims form from physicians, and eleven (11) states either require or plan to require insurers to accept the UB-82 claims form from hospitals. Nine (9) states have adopted the claims form developed by the American Dental Association (ADA) for dentists. Four (4) states have developed their own claims form for pharmacists. The National Association of Insurance Commissioners (NAIC) is also in the process of setting up a working group to study this issue. Some preliminary information obtained from the NAIC indicates that they will probably recommend adopting the HCFA-1500 for physicians, the UB-82 for hospitals, and the ADA form for dentists. They have not decided what they will recommend for pharmacists.

Based on these findings, the Bureau recommends that all accident and sickness insurers, health maintenance organizations, health services plans, and dental and optometric services plans licensed in the Commonwealth be required to accept as standard claims forms:

(i) the HCFA-1500 claims form (or its successor) for physician services and for services provided by chiropractors, audiologists, speech pathologists, clinical nurse specialists who render mental health services, physical therapists, psychologists, clinical social workers, professional counselors, podiatrists, optometrists, and opticians;

(ii) the UB-82 claims form (or its successor) for hospital services; and

(iii) the ADA claims form developed by the American Dental Association for dental services.

Payors should not be prohibited, however, from accepting any other claims form that has been determined to be acceptable by both the provider and the payor.

Because there does not appear to be a national standard form already developed for use by pharmacists, the Bureau does not recommend establishing a pharmaceutical claims form that would be unique to Virginia. The Bureau recommends that the standardized format which is being developed by the American National Standards Institute to facilitate the electronic submission of claims be used by all insuring entities as soon as the ANSI X12 837 Health Care Claim Transaction form has been adopted (see Appendix C). This form will be available for use by hospitals, physicians, dentists, pharmacists, and other health care providers.

## INTRODUCTION

### Legislative Request

The State Corporation Commission's Bureau of Insurance was requested by the 1992 General Assembly to study the feasibility of creating a universal health insurance claims form for use by all insurance carriers licensed in the Commonwealth. This study was the result of House Joint Resolution No. 241 and was requested for the following reasons:

(1) various and multiple claims forms which request duplicative and diverse information are a factor in administrative costs;

(2) completing these varying health insurance claims forms requires providers to have separate staff whose sole duty is to act as liaison for consumers and insurance carriers; and

(3) the dollars spent on administering health care could be more efficiently and effectively utilized on the provision and delivery of health care.

The study resolution also stated that it was incumbent upon the Commonwealth to examine the means by which to reduce these administrative costs and excessive paper work to make more responsible use of Virginia's health care dollars.

### Methodology

The Bureau of Insurance (Bureau) began its study by conducting a literature search and by reviewing the activities of other states to determine whether a universal health insurance claims form had been developed in other jurisdictions. Several state and federal agencies were also contacted for information on this subject.

The Bureau conducted three surveys for the study. One survey was sent to the top writers of accident and sickness insurance policies in Virginia. These companies were selected on the basis of premiums written. Twenty-five (25) companies were surveyed. The purpose of the survey was to determine whether companies would be in favor of a universal claims form, whether such a claims form would offer companies a reduction in administrative costs or whether it would increase their costs, and what types of problems they could expect to encounter if they were required to convert to a universal claims form.

A second survey was sent to one hundred (100) randomly selected physicians across the state to determine whether the use of a single health insurance claims form would simplify their work in processing claims and whether it would reduce the processing time for providers to ensure faster reimbursement. This same survey was also sent to an organization that represents managers of medical groups.

A third survey was sent to eighteen (18) advisory organizations that participated in the Task Force on Managed Health Care. Most of these associations represented special provider groups other than physicians. The purpose of this survey was similar to the survey sent to physicians but was intended to analyze the impact of the proposal from the vantage point of various state and national organizations.

**Background**

In 1991, the Virginia General Assembly requested the Board of Health Professions to study the standards and ethics for managed care systems. This request was made pursuant to House Joint Resolution No. 399 (HJR 399). In response to HJR 399, the Virginia Department of Health Professions established the Task Force on Managed Health Care which comprised members of the Board of Health Professions and other regulatory boards within the Department of Health Professions.

The Task Force on Managed Health Care conducted the 1991 study in consultation with over 45 advisory agencies and organizations including other state regulatory agencies, insurance industry representatives, provider organizations, consumer organizations, and business and industry associations. The purpose of the study was to determine the effects of managed health care on health care cost, access, and quality. One of the recommendations that came out of the study was the proposal to mandate a single claims form for all insurance systems. This particular proposal is being considered within the scope of this report as well as in another study being conducted by the Bureau in response to Senate Joint Resolution No. 120 (1992).

## MAJOR FINDINGS

### Insurance Company Survey

The first objective stated in the study resolution was to give consideration to the development of a single claims form for all health insurance systems in the Commonwealth. The Bureau began its research by sending a survey to the top writers of accident and sickness insurance policies in Virginia. These companies were selected on the basis of premiums written. Twenty-five (25) companies representing 82% of the market in Virginia were surveyed. The purpose of the insurance company survey was to determine the following:

(1) whether companies would be in favor of the creation of a universal health insurance claims form;

(2) whether companies think it would be feasible to develop a universal claims form;

(3) whether it would reduce administrative costs for companies or whether it would create additional costs;

(4) what types of problems companies would encounter if they were required to convert to a universal claims form;

(5) what types of benefits would be derived from using such a form;

(6) whether reimbursement would be handled on a more timely basis if companies were required to use the same claims form;

(7) how many companies participate in a network for the electronic transmission of health insurance claims and whether the network is restricted to their company and their participating providers; and

(8) how many companies that do not already participate in a network for the electronic transmission of health insurance claims would be willing to participate in such a network.

Out of nineteen (19) responses received, twelve (12) companies indicated that they would be in favor of the creation of a universal health insurance claims form. Eleven (11) companies said they thought it would be feasible to develop such a form. Ten (10) companies indicated that administrative costs would increase. Some of the explanations given for the expected increased expenses had to do with the following concerns:

(i) each state might have its own unique claims form with its own unique requirements;

(ii) one claims form may not develop all the information an insurer needs to know to process a claim, and additional costs might be incurred as a result of having to follow up on the initial submission;

(iii) a state-specific form would result in computer systems to accommodate modifications to the standard HCFA-1500 and UB-82 claims forms;

(iv) a new form would mean increased space for storage, additional record-keeping, and restructuring of administration kits;

(v) a new form would mean increased processing time and would increase the risk of errors.

In addition to increased costs, some of the companies noted other problems a universal claims form could create:

(i) lack of data to enforce contracts;

(ii) future processing needs or reporting requirements might not be taken into consideration when developing a new form;

(iii) creation of a new form could delay the introduction of advanced technological methods of reporting;

(iv) a universal claims form would be cumbersome and long since it would have to be designed for all health care procedures.

Thirteen (13) companies indicated on the survey that reimbursement would not be handled on a more timely basis if everyone were required to use the same claims form. However, when asked what types of benefits a universal claims form could offer, the following responses were given:

(i) increased consistency in the forms would result in less confusion on the part of providers;

(ii) administrative costs would be reduced after all systems and contracts have been changed;

(iii) processing time would be reduced;

(iv) errors would be reduced due to standard coding;

(v) expenses would be reduced;

(vi) training would be facilitated as well as interpretation of billings;

(vii) the move toward electronic data interchange would be facilitated.

Ten (10) companies that responded to the survey said they already participate in a network for the electronic transmission of health insurance claims; however, two of these companies indicated that this network was restricted to their company and/or their providers. Ten (10) companies that did not already do so said they would be willing to participate in an open network for the electronic transmission of claims.

Although the questionnaire did not ask the companies about any one particular claims form, a number of companies indicated on the survey that they already accept the national HCFA-1500 and the UB-82 claims forms and that these could be used as the standardized claims forms for Virginia. One company also mentioned that although most states do not mandate use of the HCFA-1500 and the UB-82 claims forms, many states have mandated that insurance companies accept them for payment. Several companies indicated that they would not be opposed to the establishment of a universal claims form as long as it was the HCFA-1500 for providers and the UB-82 for hospitals. Several companies also indicated that they were advocates of electronic claims submission and encouraged the development of a national electronic claims format through the American National Standards Institute.

**Physician Survey**

The Bureau also sent a survey to one hundred (100) randomly selected physicians across the state. This list was provided by the Department of Health Professions and included all physicians licensed and living in Virginia. The same survey was sent to the Virginia Medical Group Managers Association which is a state organization that represents administrators and office managers of medical groups. The purpose of the physician survey was to determine the following:

(1) whether physicians or their office managers would be in favor of the creation of a universal health insurance claims form;

(2) whether physicians or their office managers think it would be feasible to develop a universal claims form;

(3) whether it would reduce administrative costs, and if so how, or whether it would create additional costs;

(4) what types of problems physicians would encounter if they were required to convert to a universal claims form;

(5) whether reimbursement would be handled on a more timely basis if companies were required to use the same claims form;

(6) how many physicians participate in a network for the electronic transmission of health insurance claims; and

(7) how many physicians who do not already participate in a network for the electronic transmission of health insurance claims would be willing to participate in such a network.

Out of thirty (30) responses received, twenty-eight (28) physicians indicated that they would be in favor of the creation of a universal health insurance claims form. Twenty-nine (29) said they thought it would be feasible to develop such a form. Twenty-one (21) physicians said they thought it would reduce administrative costs. Estimates of cost savings varied, but the majority of respondents indicated that the cost savings would be the result of a reduction in staff time and a reduction of supplies needed for processing claims. Five (5) physicians indicated that the creation of a universal health insurance claims form would pose special problems for them such as having to redesign computer software and having to change current forms. Nineteen (19) indicated that they thought reimbursement would be handled on a more timely basis if everyone used the same claims form. Ten (10) said they already participate in a network for the electronic transmission of health insurance claims and twelve (12) said they would be willing to participate in such a network.

Although the questionnaire did not ask the physicians about any one particular claims form, two respondents said the HCFA-1500 should be used as a universal form. Two other respondents said the HCFA-1500 is essentially used by everyone now. Another respondent said the HCFA-1500 form was too complicated and time consuming to be used.

**Advisory Organization Survey**

The Bureau also sent a survey to eighteen (18) organizations that served in an advisory capacity on the Task Force for Managed Health Care. Most of the organizations selected for the survey represented providers other than physicians. The following organizations were surveyed:

Mental Health Association of Virginia
Psychiatric Society of Virginia
Virginia Academy of Clinical Psychologists
Virginia Association of Allied Health Professions
Virginia Association of Clinical Counselors
Virginia Chiropractic Association
Virginia Counselor's Association
Virginia Dental Association
Virginia Health Care Association
Virginia Health Care Coalition
Virginia Health Council
Virginia Hospital Association
Virginia Nurses' Association
Virginia Pharmaceutical Association
Virginia Psychological Association
National Association of Managed Care Physicians
Health Insurance Association of America
Medical Society of Virginia

The format of the advisory organization survey was very similar to that of the physician and company surveys. The purpose of the advisory organization survey was two-fold: (i) to determine the impact that a single claims form would have from the perspective of a variety of provider groups and (ii) to allow associations that had participated on the Task Force on Managed Health Care an opportunity to provide input for this study.

Out of sixteen (16) responses received, fifteen (15) organizations indicated that they would be in favor of the creation of a universal health insurance claims form. Fourteen (14) said they thought it would be feasible to develop such a form. Fourteen (14) said they thought it would reduce administrative costs. Eleven (11) said they thought claims reimbursement would be handled on a more timely basis if everyone used the same claims form. Four (4) favored the idea of requiring all providers and insurance carriers to participate in a network for the electronic transmission of health insurance claims.

Two of these organizations said they favored the HCFA-1500 claims form and indicated that they would not be opposed to the requirement of a standardized claims form as long as the form was not unique to the Commonwealth of Virginia. One organization mentioned that the UB-92 was in the process of being developed and that this was an update of the current form most often used by hospitals (UB-82). Two organizations said that while they supported the movement toward electronic data interchange, they did not support mandates for participation in such a network.

**State Survey**

The Bureau contacted the Texas Department of Insurance to obtain the results of a state survey the Texas Department had conducted in May, 1992. This survey was sent to all state insurance departments to determine (i) how many states have a centralized claim processing center for insurance claims and (ii) how many states have adopted a standardized health insurance claims form. By the end of June, twenty-five (25) states had responded to the survey and some preliminary information had been gathered. According to the results of the survey, only one state indicated that they had a centralized claim processing center for insurance claims and eleven (11) states indicated that they had either adopted a standardized claims form or had legislation pending. In addition to the eleven (11) states that had indicated on the Texas survey that their state had adopted a standardized claims form or had legislation pending, the Bureau learned that fifteen (15) other states were either considering adopting a standardized claims form or had already adopted one. The following shows a summary of the twenty-six states' activities:

| Claims Form Adopted | Legislation/Adoption Pending | Study in Progress |
|---|---|---|
| Alabama | California | Colorado |
| Arkansas | Maryland | Maine |
| Florida | Michigan | Montana |
| Indiana | Pennsylvania | Texas |
| Kansas | Vermont | |
| Kentucky | Wyoming | |
| Mississippi | | |
| Nevada | | |
| New York | | |
| North Dakota | | |
| Oklahoma | | |
| Oregon | | |
| South Carolina | | |
| Tennessee | | |
| West Virginia | | |
| Wisconsin | | |

Among the states that have adopted a standardized health insurance claims form or have legislation pending, thirteen (13) states either require or plan to require insurers to accept the HCFA-1500 claims form from physicians. Eleven (11) states require or plan to require insurers to accept the UB-82 claims form from hospitals. The HCFA-1500 was developed by the Uniform Claims Form Task Force which was co-chaired by the American Medical Association and the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services. The UB-82 was developed by the National Uniform Billing Committee which was co-chaired by the American Hospital Association and the Health Care Financing Administration. Nine (9) states indicated that a separate claims form is used for dentists and pharmacists. Each of these states indicated that the claims form developed by the American Dental Association is used for dentists. There does not appear to be a widely used form for pharmacists and only four (4) states indicated that a standard pharmaceutical claims form had been developed in their state.

**NAIC Proposal**

The National Association of Insurance Commissioners (NAIC) was also contacted to determine whether any consideration had been given to developing a model claims form on a national level. The NAIC is an organization of the chief regulatory officials of all of the state insurance departments. Among other functions, the NAIC provides a forum for the exchange of ideas and the formulation of uniform policy through model insurance laws and regulations. The NAIC is considering the idea of developing a model health insurance claims form. According to information obtained from NAIC staff, they are in the process of setting up a working group, and will probably propose that the HCFA-1500 be adopted as the model claims form for physicians and that the UB-

82 be adopted as the model claims form for hospitals. At this time they are not sure which form they will suggest for pharmacists, but they will probably suggest that the ADA form currently used by most dentists be adopted as the standard dental claims form.

**Survey of Other Agencies**

The Virginia Department of Medical Assistance Services was contacted, as well as the United States Department of Health and Human Services, to determine whether a universal claims form was required to be used for services provided under Medicaid and Medicare in Virginia. According to information obtained from the Virginia Department of Medical Assistance Services, the HCFA-1500 (12/90 Edition) is required to be used by physicians filing claims under both Medicaid and Medicare. Other providers such as mental health providers, podiatrists, and optometrists also use the HCFA-1500 claims form. Hospitals are required to use the UB-82 claims form. Dentists and pharmacists have their own separate forms and do not use the HCFA-1500. According to information obtained from the Social Security Administration Office of the United States Department of Health and Human Services, the HCFA-1490 SC (2/87 Edition) is used by beneficiaries to file their own Medicare claims. The Travelers Companies (the Part B Medicare carrier for part of Virginia) confirmed that the HCFA-1500 (12/90) Form was the correct form to be used by physicians for all services rendered to Medicare patients. The original effective date for this form was 1/1/92, but that date was revised to become effective on 7/1/92. Copies of these forms are shown in Appendix B.

The American National Standards Institute (ANSI) has also been working on developing a standard health insurance claims form. ANSI is the coordinator of national standards in the United States and serves as the central body responsible for the identification of a single consistent set of voluntary standards. ANSI provides an open forum for identifying, planning, and agreeing on standards. Within the ANSI organization, the Accredited Standards Committee (ASC) X12 has been established to develop standards to facilitate electronic data interchange. An insurance subcommittee, which is called the X12N subcommittee, is working on a proposal to combine into one form the HCFA-1500 and the UB-82 (this will include changes incorporated into the UB-92 when that form is adopted). The new form is being referred to within the ANSI organization as the ANSI X12 837 Health Care Claim Transaction (see Appendix C). The X12N subcommittee expects the ANSI X12 837 to be approved as a standard claims form in October. This will be approved through the ANSI Consensus Ballot process in which HCFA and approximately 800 other providers and insurers participate. According to information from the X12N subcommittee, the new form will be suitable for use by dentists and pharmacists as well as physicians and hospitals.

**Electronic Claims Processing**

One means of standardizing claims administration is through the use of electronic claims processing. Electronic claims processing eliminates paper files and enables transactions to occur instantaneously. Electronic claims processing offers the following advantages:

1. **Standardization.** Claim and billing standards are uniform.

2. **Accuracy.** Clearinghouses ensure that data is accurate.

3. **Reduced Costs.** Providers can reduce administrative staff and payors can reduce clerical staff.

4. **Faster Payment.** Providers can be paid daily. Bank accounts can be credited through electronic funds transfer, thus eliminating paper bills and mailings.

5. **Fraud Control.** Fraudulent claim activity can be identified more quickly and questionable practices flagged.[1]

Companies are already entering the marketplace to provide electronic claims processing services. According to information submitted to the Bureau by the Mid-Atlantic Medical Counsel, over fifty-six (56) public and private insurance payors participate in electronic claims processing. The Mid-Atlantic Medical Counsel is an organization that, in association with GTE Health Systems Incorporated and the National Electronic Information Corporation (NEIC), offers electronic claims processing services to physicians and health care providers in the Commonwealth and throughout the Mid-Atlantic region. Their goals are to reduce paper work and administrative costs, file claims within twenty-four (24) hours of the date of service, report rejected claims and refile amended claims forms within ninety-six (96) hours of service, and have payment rendered within twenty-one (21) days of service. The president of Mid-Atlantic Medical Counsel indicates that both of these electronic claims clearinghouses (GTE and NEIC) subscribe to the ANSI X12 standards set by the American National Standards Institute. A list of NEIC participating payors is shown in Appendix D of this report.

Blue Cross and Blue Shield of Virginia (BCBSVA) has also developed a system for the electronic transmission of claims data and payment using the ANSI 820 standardized remittance format. The company plans to convert to the ANSI 835 format. Healthcare Communication Services (HCS), which is a wholly owned subsidiary of BCBSVA, serves as a health claims clearinghouse for Blue Cross and Blue Shield plans. By establishing a paperless claims submission process, the company is able to operate more efficiently through a reduction in postage expenses, a reduction in check and envelope costs, a reduction in processing errors, improved processing time, and streamlined operations.[2]

The concept of mandating the use of electronic claims processing was also considered at the federal level. One of the proposals in a bill recently introduced in Congress, the "Health Insurance Purchasing Cooperatives Act" (S.2675), would have required participating insurers to use electronic administration of claims and billing. Under this proposal, a national health insurance data system would have been established and would have consisted of (i) a centralized national data base for health insurance and health outcomes information; (ii) a network of no more than five regional health insurance data collection centers; and (iii) a standardized, universal mechanism for electronically processing health insurance and health outcomes data. A national health board would have established uniform billing and claims forms and mandatory reporting requirements including information on member eligibility, benefits, use, outcomes, and efficacy. No action was taken on this bill.

In a separate proposal put together by the Bush Administration, a computerized health billing system would have been implemented which would have given Secretary of Health and Human Services Louis W. Sullivan the power to require insurers to use standardized computer software and uniform claims formats. The President's proposal anticipated a savings of $4 billion the first year and $20 billion annually by the year 2000. [3] No action was taken on this bill.

The House Ways and Means Committee has also studied the issue of computerization in health care administration. In testimony given before the House Ways and Means Subcommittee on Health, Joseph T. Brophy, the co-chair of the Work Group on Electronic Data Interchange (WEDI), cited the benefits of electronic data interchange, but he warned Congress to "resist the impulse to legislate prematurely." In his statement, the co-chair advised the subcommittee that the government should ensure the proper environment in which electronic data interchange can flourish but should "refrain from micro-managing the process." He also stated that rather than instituting penalties and mandates, the government should provide incentives to encourage the development of electronic data processing.[4]

In a recent report issued by the United States General Accounting Office (GAO), a recommendation was made to create a national commission to study health care fraud and abuse. As envisioned by the GAO, one of the directives of the commission would be to develop recommendations to promote greater standardization in claims administration. In doing so, some of the obstacles which currently stand in the way of detecting and preventing fraud would be removed. The GAO report pointed out that, with 1,000 insurers processing four billion health care claims a year and with providers and insurers using different payment methods and billing standards, the health care system is especially vulnerable to fraud and abuse. The commission would be responsible for establishing ways to ease the exchange of information without undermining legitimate patient and provider privacy concerns. Also mentioned in the GAO report was the Forum

on Administrative Costs which convened in November, 1991, and which proposed certain administrative reforms that included (i) electronic billing using standardized formats and (ii) computerized medical record systems for providers. Working groups have been in the process of implementing these reforms.[5]

Despite the fact that over 450 claims forms are currently in existence, most of the differences in data requirements are small and many data fields are identical; they are simply labeled with different words.[6] If payors and providers are willing to subscribe to a universal set of data requirements, standardization through the use of an electronic claims processing system can cut processing costs by as much as 25-40 percent. This will substantially reduce the claims processing costs for insurers, hospitals, and physicians who, in 1991, spent $79.8 billion for claims processing.[7] Three major health care payors have already announced their support for standardization in electronic data interchange through the use of the ANSI X12 format. These payors are the Blue Cross and Blue Shield Association, Travelers, and HCFA (payors under Medicare). If ANSI standards are adopted universally, the costs of health care claims administration can be reduced and quality improved.[8]

## RECOMMENDATIONS

Based on the findings contained in this report, the Bureau of Insurance recommends that accident and sickness insurers, health maintenance organizations, health services plans, and dental and optometric services plans be required to accept certain standardized claims forms but that they be allowed to accept other claims forms as well.

Under this proposal, accident and sickness insurers, health maintenance organizations, health services plans, and optometric services plans would be required to accept the HCFA-1500 claims form (or its successor) as a standard claims form for physician services and for services provided by chiropractors, audiologists, speech pathologists, clinical nurse specialists who render mental health services, physical therapists, psychologists, clinical social workers, professional counselors, podiatrists, optometrists, and opticians. Payors would not be prohibited, however, from accepting other claims forms if the provider and the payor agreed upon a different claims form.

For hospital services rendered, accident and sickness insurers, health maintenance organizations, and health services plans would be required to accept the UB-82 claims form (or its successor), but they would not be prohibited from accepting other agreed-upon claims forms.

For dental services rendered, accident and sickness insurers, health maintenance organizations, health services plans, and dental services plans would be required to accept the ADA form prepared by the American Dental Association, but another claims form considered acceptable by both parties could also be used.

Because there does not appear to be a national standard form already developed for use by pharmacists, the Bureau does not recommend establishing a pharmaceutical claims form that would be unique to Virginia. The Bureau recommends that the standardized format which is being developed by the American National Standards Institute to facilitate the electronic submission of claims be used by all insuring entities as soon as the ANSI X12 837 Health Care Claim Transaction form has been adopted. This form will be available for use by hospitals, physicians, dentists, pharmacists, and other health care providers.

The Bureau recommends that the following language be incorporated as a new section under Chapter 3 of Title 38.2 of the Code of Virginia to become effective on and after January 1, 1994:

**§38.2-322. Standardized Claims Forms.** A. No accident and sickness insurer, health maintenance organization, health services plan, or optometric services plan licensed in the Commonwealth shall refuse to accept, as a standard claims form for physician services or for services provided by chiropractors, optometrists, opticians, professional counselors, psychologists, clinical social workers, podiatrists, physical therapists, clinical nurse specialists who render mental health services, audiologists, and speech pathologists, the standardized HCFA-1500 health insurance claims form, or its successor as it may be amended from time to time. However, nothing in this section shall prohibit an insurer, health maintenance organization, health services plan, or optometric services plan from accepting any other claims form.

B. No accident and sickness insurer, health maintenance organization, or health services plan licensed in the Commonwealth shall refuse to accept as a standard claims form for hospital services the standardized UB-82 claims form, or its successor as it may be amended from time to time. However, nothing in this section shall prohibit an accident and sickness insurer, health maintenance organization, or health services plan from accepting any other claims form.

C. No accident and sickness insurer, health maintenance organization, health services plan, or dental services plan licensed in the Commonwealth shall refuse to accept as a standard claims form for dental services the standardized ADA form

prepared by the American Dental Association, or its successor as it may be amended from time to time. However, nothing in this section shall prohibit an accident and sickness insurer, health maintenance organization, health services plan, or dental services plan from accepting any other claims form.

D. The forms specified in this section may be modified as necessary to accommodate the transmission and administration of claims by electronic means.

**ENDNOTES**

(1)"The New Electronic Revolution," At Issue, National Association of Health Underwriters, Washington, June 7, 1992, pp. 2-3.

(2) John M. Miller V, CCM, "Innovations in Paperless Insurance Claims Processing and Payment," Journal of Cash Management, May/June 1992, pp. 53-54.

(3) Rick Pullen, "Bush Proposes Streamlined Health Billing System," Best's Insurance Management Reports, June 29, 1992, p.1.

(4) At Issue, pp.2-3.

(5) Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May, 1992).

(6) At Issue, p.2.

(7) Howard J. Anderson, "Insurers See EDI as Key Ingredient of Cost Cutting", Hospitals, April 20, 1992, p.51.

(8) "Key Health Payors Back Common Data Format," National Underwriter, Life & Health/Financial Services, June 29, 1992, p. 16.

# APPENDIX A

# GENERAL ASSEMBLY OF VIRGINIA--1992 SESSION

## HOUSE JOINT RESOLUTION NO. 241

*Requesting the Bureau of Insurance of the State Corporation Commission to study the feasibility of developing a universal health insurance claim form.*

Agreed to by the House of Delegates, February 9, 1992
Agreed to by the Senate, March 4, 1992

WHEREAS, in 1991, the cost of health care in the United States was almost 13 percent of the gross national product; and

WHEREAS, no other country uses more than nine percent of its gross national product for this purpose, the average being between six and one-half percent and eight percent; and

WHEREAS, one estimate shows that 20 percent of the United States health care system's funds is dedicated to the administration of health care; and

WHEREAS, these administrative costs have burdened the health care system with billions of dollars in unnecessary costs; and

WHEREAS, a study's findings suggest that had the United States administration of health care been as efficient as Canada's, $69.0 billion to $83.2 billion would have been saved in 1987; and

WHEREAS, various and multiple health insurance claim forms requesting both duplicative and diverse information are a factor in administrative costs; and

WHEREAS, to complete these varying health insurance claim forms, providers must generally have separate staff whose sole duty is to act as liaison for consumers and insurance carriers; and

WHEREAS, clearly, those dollars spent on administering health care could be more efficiently and effectively utilized on the provision and delivery of health care; and

WHEREAS, an examination of means to reduce these administrative costs and excessive paper work is incumbent on the Commonwealth's obligation to its citizens for a more responsible use of Virginia's health care dollars; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Bureau of Insurance of the State Corporation Commission be requested to study the feasibility of creating a universal health insurance claims form for use by all insurance carriers licensed in the Commonwealth; and, be it

RESOLVED FURTHER, That all companies licensed and regulated for the business of providing health insurance in the Commonwealth work in cooperation with the Bureau of Insurance in the Bureau's deliberations.

The Bureau shall complete it work in time to report its findings and recommendations to the Governor and the 1993 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

# APPENDIX B

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

# HEALTH INSURANCE CLAIM FORM

PICA

| 1 MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (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 ☐ F ☐ | | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
| 5 PATIENT'S ADDRESS (No., Street) | | | | 6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐ | | | 7. INSURED'S ADDRESS (No., Street) |
| CITY | | | STATE | 8. PATIENT STATUS Single ☐ Married ☐ Other ☐ | | | CITY / STATE |
| ZIP CODE | TELEPHONE (Include Area Code) ( ) | | | Employed ☐ Full-Time Student ☐ Part-Time Student ☐ | | | 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) ☐ YES ☐ NO | | | a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐ |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐ | | | | b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) | | | b. EMPLOYER'S NAME OR SCHOOL NAME |
| c. EMPLOYER'S NAME OR SCHOOL NAME | | | | c. OTHER ACCIDENT? ☐ YES ☐ 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? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d. |

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

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: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / MM DD YY TO |
|---|---|---|
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 17a. I.D. NUMBER OF REFERRING PHYSICIAN | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / MM DD YY TO |
| 19. RESERVED FOR LOCAL USE | | 20. OUTSIDE LAB? ☐ YES ☐ NO / $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. ____ 3. ____ 2. ____ 4. ____ | | 22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. |
| | | 23. PRIOR AUTHORIZATION NUMBER |

| 24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |

| 25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐ | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see 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.) SIGNED DATE | 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 # PIN# GRP# | | |

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

APPROVED OMB NO. 0938-0279

| | | | | |
|---|---|---|---|---|
| | 2 | | 3 PATIENT CONTROL NUMBER | 4 TYPE OF BILL |
| 5 BC / BS PROV NO. | 6 FEDERAL TAX NO | 7 MEDICARE NO | 8 MEDICAID NO | 9 |
| PATIENT'S LAST NAME / FIRST NAME / INITIAL | 11 PATIENT'S ADDRESS | CITY | STATE | ZIP |

| 12 BIRTH DATE | 13 SEX | 14 MS | ADMISSION 15 DATE | 16 HR. | 17 TYPE | 18 SRC | 19 A H | 20 O H | 21 STAT | 22 STATEMENT COVERS PERIOD FROM | THROUGH | 23 COV D | 24 N-C D | 25 C-I D | 26 L-R D | 27 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| 28 OCCURRENCE CD | DATE | 29 OCCURRENCE CD | DATE | 30 OCCURRENCE CD | DATE | 31 OCCURRENCE CD | DATE | 32 OCCURRENCE CD | DATE | 33 OCCURRENCE SPAN CD | FROM | THROUGH |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |

| 34 | CONDITION CODES 35 | 36 | 37 | 38 | 39 | BLOOD RECORD (PINTS) 40 PURN | 41 REPL | 42 NOT RP | 43 DED | 44 SP PROG. | 45 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

| | 46 VALUE CD | AMT | 47 VALUE CD | AMT | 48 VALUE CD | AMT | 49 VALUE CD | AMT |
|---|---|---|---|---|---|---|---|---|
| a | | | | | | | | |
| b | | | | | | | | |

| 50 DESCRIPTION | 51 R. CODE | 52 S UNITS | 53 TOTAL CHARGES | 54 | 55 | 56 |
|---|---|---|---|---|---|---|
| | | | | | | |

| 57 PAYER | 58 REL INFO | 59 ASG BEN | 60 DEDUCTIBLE | 61 CO-INSURANCE | 62 EST RESPONSIBILITY | 63 PRIOR PAYMENTS | 64 EST AMOUNT DUE |
|---|---|---|---|---|---|---|---|
| A | | | | | | | |
| B | | | | | | | |
| C | | | | | | | |

**DUE FROM PATIENT ▶**

| 65 INSURED'S NAME | 66 SEX | 67 P REL | 68 CERT -SSN - HIC - ID NO | 69 GROUP NAME | 70 INSURANCE GROUP NO |
|---|---|---|---|---|---|
| A | | | | | |
| B | | | | | |
| C | | | | | |

| 71 EID | 72 ESC | 73 EMPLOYER NAME | 74 EMPLOYEE ID | 75 EMPLOYER LOCATION |
|---|---|---|---|---|
| | | | | |

| 76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS | 77 PRIN. CODE | OTHER DIAGNOSES CODES 78 | 79 | 80 | 81 |
|---|---|---|---|---|---|
| | | | | | |

| 82 P.C. | 83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS | 84 PRINCIPAL PROCEDURE CD | DATE | 85 OTHER PROCEDURE CD | DATE | 86 OTHER PROCEDURE CD | DATE |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| PSRO UR DATA 87 CD | 88 APP. FROM | 89 APP. THROUGH | 90 GRC | 91 TREATMENT AUTH | 92 ATTENDING PHYSICIAN ID | 80 OTHER PHYSICIAN ID |
|---|---|---|---|---|---|---|
| | | | | | | |

EMARKS

| FOR INTERMEDIARY USE ONLY VERIFIED N-C STAY DATES FROM | THROUGH | PR PSC D. | |
|---|---|---|---|
| | | | |

| AMT REIMBURSED | N-PYM. CD | | | APPROV BY | DATE APPROV |
|---|---|---|---|---|---|
| | | | | | |

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

UB-82 HCFA-1450

PAYER COPY

PROVIDER REPRESENTATIVE X

96 DATE

# ental Claim Form

heck one:

Dentist's pre-treatment estimate

Dentist's statement of actual services

**Carrier name and address**

| 1. Patient name (first, m.i., last) | 2. Relationship to employee | 3. Sex (m / f) | 4. Patient birthdate (MM DD YYYY) | 5. If full time student (school, city) |
|---|---|---|---|---|
| | ☐ self ☐ child ☐ spouse ☐ other | | | |

| 6. Employee/subscriber name and mailing address | 7. Employee/subscriber soc. sec. or I.D. number | 8. Employee/subscriber birthdate (MM DD YYYY) | 9. Employer (company) name and address | 10. Group number |
|---|---|---|---|---|
| | | | | |

| 11. Is patient covered by another dental plan? ☐ yes ☐ no If yes, complete 12-a. Is patient covered by a medical plan? ☐ yes ☐ no | 12-a. Name and address of carrier(s) | 12-b. Group no.(s) | 13. Name and address of other employer(s) |
|---|---|---|---|
| | | | |

| 14-a. Employee/subscriber name (if different than patient's) | 14-b. Employee/subscriber soc. sec. or I.D. number | 14-c. Employee/subscriber birthdate (MM DD YYYY) | 15. Relationship to patient ☐ self ☐ parent ☐ spouse ☐ other |
|---|---|---|---|
| | | | |

**have reviewed the following treatment plan. I authorize release of any information lating to this claim. I understand that I am responsible for all costs of dental treatment.**

igned (Patient, or parent if minor) Date

**I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.**

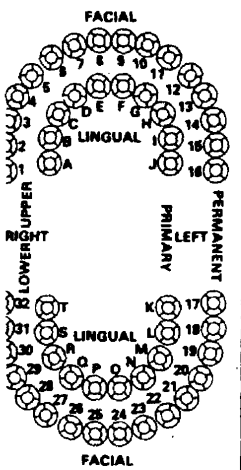
▶ Signed (insured person) Date

| 16. Name of Billing Dentist or Dental Entity | 24. Is treatment result of occupational illness or injury? | No | Yes | If yes, enter brief description and dates. |
|---|---|---|---|---|
| 17. Address where payment should be remitted | 25. Is treatment result of auto accident? | | | |
| City, State, Zip | 26. Other accident? | | | |

| 18. Dentist Soc. Sec. or T.I.N. | 19. Dentist license no. | 20. Dentist phone no. | 27. If prosthesis, is this initial placement? | | (If no, reason for replacement) | 28. Date of prior placement |
|---|---|---|---|---|---|---|
| | | | | | | |

| 21. First visit date current series | 22. Place of treatment (Office, Hosp., ECF, Other) | 23. Radiographs or models enclosed? | No | Yes | How many? | 29. Is treatment for orthodontics? | | If services already commenced enter: | Date appliances placed | Mos. tre remaini |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

entify missing teeth with "x"




30. Examination and treatment plan — List in order from tooth no. 1 through tooth no. 32 — Use charting system shown.

| Tooth # or letter | Surface | Description of service (including x-rays, prophylaxis, materials used, etc.) | Date service performed Mo. Day Year | Procedure number | Fee |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

For administrative use only

31. Remarks for unusual services

**reby certify that the procedures as indicated by date have been completed and that the fees submitted the actual fees I have charged and intend to collect for those procedures.**

ed (Treating Dentist) License Number Date

| | |
|---|---|
| **Total Fee Charged** | |
| Max. Allowable | |
| Deductible | |
| Carrier % | |
| Carrier pays | |
| Patient pays | |



)

[redacted]

FORM APPROVED
OMB NO. 0938-0008

# PATIENT'S REQUEST FOR MEDICAL PAYMENT

**IMPORTANT—SEE OTHER SIDE FOR INSTRUCTIONS**

PLEASE TYPE OR PRINT INFORMATION

MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

1 Name of Beneficiary from Health Insurance Card
(Last) (First) (Middle)

**SEND COMPLETED FORM TO:**

2 Claim Number from Health Insurance Card

Patient's Sex
☐ Male
☐ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address → ☐

(Street or P.O. Box — Include Apartment Number)

(City) (State) (Zip)

3b Telephone Number
(Include Area Code)
(___ ___ ___)
___ ___ ___ – ___ ___ ___ ___

4 Describe the Illness or Injury for which Patient Received Treatment

4b Was condition related to:
A. Patient's employment
☐ Yes ☐ No
B. Accident
☐ Auto ☐ Other

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☐ No

5 a. Are you employed and covered under an employee health plan? ☐ Yes ☐ No

b. Is your spouse employed and are you covered under your spouse's employee health plan? ☐ Yes ☐ No

c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:
Name and Address of other insurance, State Agency (Medicaid), or VA office

Policy or Medical Assistance No.

Policyholders Name:

NOTE: If you DO NOT want payment information on this claim released, put an (X) here → ☐

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

Signature of Patient (If patient is unable to sign, see Block 6 on reverse)

6b Date signed

**IMPORTANT**
**ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM**

# APPENDIX C

ASC X12-ELECTRONIC DATA INTERCHANGE (EDI)

Accredited Standards Committee
operating under the procedures of the
American National Standards Institute

X12N Insurance Subcommittee
Lee Barrett - Chairman
The Travelers
One Tower Square - 5 FP
Hartford, CT 06183
TEL: 203 277-7647 FAX: 203 277-2107

Document No.:

July 3, 1992

Ms. Joanne Scott
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

Dear Ms. Scott:

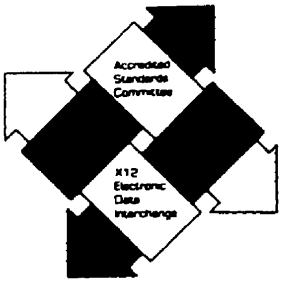
In accordance with your request to Lee Barrett, enclosed please find a copy of Health Care Claim Transaction 837.

Please let me know if you need further information.

Sincerely,

Mike Braddon

Mike Braddon
203 277-9389



# 837 Health Care Claim

FUNCTIONAL GROUP=HE

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This standard can be used to submit health care claim billing information from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required.

For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups.

DMIn:

264192

Table 1

| POS. NO. | SEG. ID | NAME | REQ. DES. | MAX. USE | LOOP REPEAT | NOTES & COMMENTS |
|---|---|---|---|---|---|---|
| 005 | ST | Transaction Set Heacer | M | 1 | | |
| 010 | BGN | Beginning Segment | O | 1 | | |
| 015 | REF | Reference Numbers | O | 3 | | |
| 020 | NM1 | Individual or Organizational Name | O | 1 | 1000/10 | NTE |
| 025 | N2 | Additional Name Information | O | 2 | | |
| 030 | N3 | Address Information | O | 2 | | |
| 035 | N4 | Geographic Location | O | 1 | | |
| 040 | REF | Reference Numbers | O | 2 | | |
| 045 | PER | Administrative Communications Contact | O | 2 | | |

Table 2

| POS. NO. | SEG. ID | NAME | REQ. DES. | MAX. USE | LOOP REPEAT | NOTES & COMMENTS |
|---|---|---|---|---|---|---|
| 005 | PRV | Provider Information | M | 1 | 2000/100 | NTE |
| 010 | CUR | Currency | O | 1 | | |
| 015 | NM1 | Individual or Organizational Name | O | 1 | 2010/2 | NTE |
| 020 | N2 | Additional Name Information | O | 2 | | |
| 025 | N3 | Address Information | O | 2 | | |
| 030 | N4 | Geographic Location | O | 1 | | |
| 035 | REF | Reference Numbers | O | 20 | | |
| 040 | PER | Administrative Communications Contact | O | 2 | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 045 | SBR | Subscriber Information | M | 1 | 2100/99999 | NTE |
| 050 | DTP | Date or Time or Period | O | 5 | | |
| 055 | NM1 | Individual or Organizational Name | O | 1 | 2110/10 | NTE |
| 060 | N2 | Additional Name Information | O | 2 | | |
| 065 | N3 | Address Information | O | 2 | | |
| 070 | N4 | Geographic Location | O | 1 | | |
| 075 | DMG | Demographic Information | O | 1 | | |
| 080 | PER | Administrative Communications Contact | O | 2 | | |
| 085 | REF | Reference Numbers | O | 5 | | |
| 090 | PAT | Patient Information | M | 1 | 2200/99 | |
| 095 | NM1 | Individual or Organizational Name | O | 1 | 2210/10 | NTE |
| 100 | N2 | Additional Name Information | O | 2 | | |
| 105 | N3 | Address Information | O | 2 | | |
| 110 | N4 | Geographic Location | O | 1 | | |
| 115 | DMG | Demographic Information | O | 1 | | |
| 120 | PER | Administrative Communications Contact | O | 2 | | |
| 125 | REF | Reference Numbers | O | 5 | | |
| 130 | CLM | Health Claim | M | 1 | 2300/100 | |
| 135 | DTP | Date or Time or Period | O | 40 | | |
| 140 | CL1 | Claim Codes | O | 1 | | |
| 145 | DN1 | Orthodontic Information | O | 1 | | |
| 150 | DN2 | Tooth Summary | O | 35 | | |
| 155 | PWK | Paperwork | O | 10 | | |
| 160 | CN1 | Contract Information | O | 1 | | |
| 165 | DSB | Disability Information | O | 1 | | |
| 170 | UR | Peer Review Organization or Utilization Review | O | 1 | | |
| 175 | AMT | Monetary Amount | O | 40 | | |
| 180 | REF | Reference Numbers | O | 10 | | |
| 185 | K3 | File Information | O | 10 | | NTE |
| 190 | NTE | Note/Special Instruction | O | 4 | | NTE |
| 195 | CR1 | Ambulance Certification | O | 1 | | NTE |
| 200 | CR2 | Chiropractic Certification | O | 1 | | |
| 205 | CR3 | Durable Medical Equipment Certification | O | 1 | | |
| 210 | CR4 | Enteral or Parenteral Therapy Certification | O | 3 | | |
| 215 | CR5 | Oxygen Therapy Certification | O | 1 | | |
| 220 | CRC | Certification Conditions | O | 3 | | |
| 225 | PC | Procedure Codes | O | 25 | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 230 | AM1 | Informational Values | O | 25 | | | |
| 235 | CD2 | Multi-Valued Characteristics | O | 30 | | | |
| 240 | QTY | Quantity | O | 10 | | | |
| 245 | LS | Loop Header | O | 1 | | | |
| 250 | NM1 | Individual or Organizational Name | O | 1 | 2310/9 | | NTE |
| 255 | PRV | Provider Information | O | 1 | | | |
| 260 | N2 | Additional Name Information | O | 2 | | | |
| 265 | N3 | Address Information | O | 2 | | | |
| 270 | N4 | Geographic Location | O | 1 | | | |
| 275 | PER | Administrative Communications Contact | O | 2 | | | |
| 280 | LE | Loop Trailer | O | 1 | | | |
| 285 | LX | Assigned Number | O | 1 | 2400/10000 | | NTE |
| 290 | SV1 | Professional Service | O | 1 | | | |
| 295 | SV2 | Institutional Service | O | 1 | | | |
| 300 | SV3 | Dental Service | O | 1 | | | |
| 305 | SV4 | Drug Service | O | 1 | | | |
| 310 | LIN | Item Identification | O | 1 | 2410/10 | | NTE |
| 315 | CTP | Pricing Information | O | 1 | | | |
| 320 | SV5 | Durable Medical Equipment Service | O | 1 | | | |
| 325 | SV6 | Anesthesia Service | O | 1 | | | |
| 330 | SV7 | Drug Adjudication | O | 1 | | | |
| 335 | CD2 | Multi-Valued Characteristics | O | 5 | | | |
| 340 | PWK | Paperwork | O | 10 | | | |
| 345 | CR1 | Ambulance Certification | O | 1 | | | NTE |
| 350 | CR2 | Chiropractic Certification | O | 5 | | | |
| 355 | CR3 | Durable Medical Equipment Certification | O | 1 | | | |
| 360 | CR4 | Enteral or Parenteral Therapy Certification | O | 3 | | | |
| 365 | CR5 | Oxygen Therapy Certification | O | 1 | | | |
| 370 | CRC | Certification Conditions | O | 3 | | | |
| 375 | DTP | Date or Time or Period | O | 15 | | | |
| 380 | QTY | Quantity | O | 5 | | | |
| 385 | CN1 | Contract Information | O | 1 | | | |
| 390 | REF | Reference Numbers | O | 10 | | | |
| 395 | AMT | Monetary Amount | O | 15 | | | |
| 400 | K3 | File Information | O | 10 | | | NTE |
| 405 | NTE | Note/Special Instruction | O | 10 | | | NTE |
| 410 | PS1 | Purchase Service | O | 1 | | | |
| 415 | LS | Loop Header | O | 1 | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 420 | NM1 | Individual or Organizational Name | O | 1 | 2420/10 | | | NTE |
| 425 | PRV | Provicer Information | O | 1 | | | | |
| 430 | N2 | Additional Name Information | O | 2 | | | | |
| 435 | N3 | Address Information | O | 2 | | | | |
| 440 | N4 | Geographic Location | O | 1 | | | | |
| 445 | PER | Administrative Communications Contact | O | 2 | | | | |
| 450 | LE | Loop Trailer | O | 1 | | | | |
| 455 | LS | Loop Header | O | 1 | | | | |
| 460 | NM1 | Individual or Organizational Name | O | 1 | 2500/10 | | | NTE |
| 465 | N2 | Additional Name Information | O | 2 | | | | |
| 470 | N3 | Address Information | O | 2 | | | | |
| 475 | N4 | Geographic Location | O | 1 | | | | |
| 480 | PER | Administrative Communications Contact | O | 1 | | | | |
| 485 | SBR | Subscriber Information | O | 1 | | | | |
| 490 | CA1 | Claim Adjudication | O | 1 | | | | NTE |
| 495 | AMT | Monetary Amount | O | 15 | | | | |
| 500 | DMG | Demographic Information | O | 1 | | | | |
| 505 | DTP | Date or Time or Period | O | 2 | | | | |
| 510 | REF | Reference Numbers | O | 3 | | | | |
| 515 | LE | Loop Trailer | O | 1 | | | | |
| 520 | SE | Transaction Set Trailer | M | 1 | | | | |

## Notes & Comments — Table 1

| POS. NO. | TYPE | TEXT |
|---|---|---|
| 020 | NTE | Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurence to the loop as a form of identification. The added loop occurence must be the last occurence of the loop. |

## Notes & Comments — Table 2

| POS. NO. | TYPE | TEXT |
|---|---|---|
| 005 | NTE | A sample of the overall structure of Table 2 of the 837 Transaction Set is:<br>2000 PROVIDER (Billing Provider)<br>2100 SUBSCRIBER<br>2200 PATIENT<br>2300 CLAIM<br>2400 SERVICE LINE(S)<br>2500 INSURANCE<br>2300 CLAIM<br>2400 SERVICE LINE(S)<br>2200 PATIENT<br>2300 CLAIM<br>2400 SERVICE LINE(S)<br>2500 INSURANCE<br>2100 SUBSCRIBER<br>2200 PATIENT<br>2300 CLAIM<br>2300 CLAIM<br>2000 PROVIDER (Billing Provider)<br>2100 SUBSCRIBER<br>2200 PATIENT<br>2300 CLAIM<br>2400 SERVICE LINE(S)<br>2500 INSURANCE<br>2100 SUBSCRIBER<br>2200 PATIENT<br>2300 CLAIM |
| 015 | NTE | Loop 2010 contains provider information:<br>• Billing Provider Information<br>• Pay-To Provider |
| 045 | NTE | Loop 2100 contains information about the subscriber of the current insurance carrier. |
| 055 | NTE | Loop 2110 contains name and address information for:<br>• Subscriber<br>• Subscriber's Current Insurance Carrier<br>• Subscriber's School or Employer |
| 095 | NTE | Loop 2210 contains name and address information for:<br>• Patient<br>• Patient's Legal Representative<br>• Party Responsible for the Patient |
| 185 | NTE | The K3 segment contains information specific to any Federal, State or Plan changes. |
| 190 | NTE | The NTE segment contains diagnosis description information and certification narrative information. |
| 195 | NTE | The CR1 through CR5 and CRC certification segments appear on both the claim level and the service line level because certifications can be submitted for all services on a claim or for individual services. Cerfication information at the claim level applies to all service lines of the claim, unless overridden by certification information at the service line level. |
| 250 | NTE | Loop 2310 contains information about the provider rendering the service(s). This provider name and address information will apply to all service lines of the claim, unless overridden by provider information at the service line level. This information can also be facility identification information or oxygen therapy facility information. |

## Notes & Comments — Table 2

| POS. NO. | TYPE | TEXT |
|---|---|---|
| 285 | NTE | Loop 2400 contains Service Line information. |
| 310 | NTE | Loop 2410 contains compound drug components, quantities and prices. |
| 345 | NTE | The CR1 through CR5 and CRC certification segments appear on both the claim level and the service line level because certifications can be submitted for all services on a claim or for individual services. Certification information at the claim level applies to all service lines of the claim, unless overridden by certification information at the service line level. |
| 400 | NTE | The K3 segment contains information specific to any Federal, State, or Plan changes. |
| 405 | NTE | The NTE segment contains certification narrative information. |
| 420 | NTE | Loop 2420 contains information about the provider rendering the service detailed on the service line. These segments override the information in the claim-level segments (within loop 2310), if the entity identifier codes in each segment are the same. This information can also be purchased service information or oxygen therapy facility information. |
| 460 | NTE | Loop 2500 contains insurance information about:<br>• Paying and Other Insurance Carriers for that Subscriber<br>• Subscriber of the Other Insurance Carriers<br>• School or Employer Information for that Subscriber<br>• Segments NM1 - N4 contain name and address information of the insurance carriers referenced in the above note. |
| 490 | NTE | The CA1 segment contains crossover data. |

# APPENDIX D

# MID-ATLANTIC MEDICAL COUNSEL

## NEIC PARTICIPATING PAYORS

*14-Feb-92*

*Acordia Benefits of Florida*
*Aetna Health Plans - PPO*
*Aetna Life & Casualty Company*
*American General Group*
*American Healthnet - Texas*
*American Postal Workers Union (APWU)*
*Enthem-Florida Health Network*
*Anthem Group Services*
*Anthem Health Plan*
*Anthem Life Insurance*
*Benefit Trust Life Insurance Company*
*CIGNA (Connecticut General Life)*
*CIGNA Health Plan - HMO*
*CNA Insurance Companies*
*CNA Mailhandlers*
*Confederation Life Insurance company*
*Confed Admin Services Inc*
*Connecticut General Life Insurance*
*EBA - Employee Benefit America*
*EQUICOR (CIGNA)*
*Florida Health Network*
*General American Life Insurance Company*
*Georga Power Co.*
*Great Southern Life (Modern American Life Insurance Company)*
*Great- Western Life Assurance Company of America*
*The Guardial Life Insurance Company of America*
*Gulf Group Services*
*HCN - Health Care Network - Milwaukee*
*Health Economics Corporation*
*Health Net - California*
*Health Net - Kansas City, Mo*
*Healthpoint Corporation*
*Healthy Choice*
*ICH Corporation*
*John Hancock Mutual Life Insurance Company*
*John Hancock Health Security Program*
*John Hancock Preferred Health PLan*
*Liberty Life Insurance Compnay*
*Life Insurance of Georgia*

# NEIC PARTICIPATING PAYORS - CONT.

*Med Connect - Chicago*
*Metropolitan Life Insurance Company*
*Modern American Life Insurance Company*
*Mutual of Omaha Insurance Company*
*Mutually Preferred*
*The New England*
*New York Life Insurance Company*
*Pacific Mutual Life Insurance Company*
*Pacific Health Systems*
*Philadelphia American Life Insurance Company*
*The Phoenix*
*Phoenix Mutual Life*
*PMG*
*Peferred One - Minneapolis*
*Principal Financial Group (formerly Bankers Life of Iowa)*
*Principal Mutual Life Insurance Company*
*Provident Life and Accident Insurance Company*
*Provident Life and Accident Insurance Company of America*
*Provident Life and Casualty Insurance Company*
*Prudential Life Insurance*
*Sagamore - South Bend Indiana*
*Sanus - St. Louis, Missouri*
*Sanus PPO*
*State Mutual Life Insurance Company of America*
*The Travelers*
*United Benefit Life Insurance*
*United of Omaha*