

VERMONT DEPARTMENT OF BANKING, INSURANCE AND SECURITIES

**REGULATION 93-4
UNIFORM CLAIM FORMS AND UNIFORM STANDARDS
AND PROCEDURES FOR PROCESSING**

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Section 1. Purpose.

The purpose of this regulation is to promote efficiency and cost savings in the payment of health insurance claims by the use of common claim forms and procedures and to improve the availability and consistency of health services information.

Section 2. Authority.

This regulation is issued pursuant to the authority vested in the Commissioner of Banking, Insurance and Securities (Commissioner) under Title 18 V.S.A. 9408.

Section 3. Applicability and Scope.

Except as otherwise specifically provided, the requirements of this regulation apply to all issuers of policies or contracts of insurance, administrators of self-funded employee benefit plans, and other forms of insurance involved in the reimbursement of health care expenses, and all providers of health care licensed or certificated by this state.

Section 4. Definitions.

- (a) “ADA claim form” means the uniform dental claim form approved by the American Dental Association for use by dentists.

- (b) “CDT codes” means the current dental terminology published by the American Dental Association.
- (c) “CPT-4 codes” means the current procedural terminology used by the American Medical Association.
- (d) “DSM-III-R codes” means the American Psychiatric Association’s codes for mental disorders.
- (e) “Durable Medical Equipment” means equipment which (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) generally is not useful to a person in the absence of an illness or injury; and (d) is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be durable medical equipment.
- (f) “HCFA” means the federal Health Care Financing Administration of the United States Department of Health and Human Services.
- (g) “HCFA-1450” (UB-82 or UB-92) means the health insurance claims form published by HCFA for use by institutional providers.
- (h) “HCFA-1500” means the health insurance claims form published by HCFA for use by health care professionals.
- (i) “HCPCS codes” means HCFA’s common procedure coding system which includes both of the following:
 - (1) Level 1 codes, which are CPT codes; and
 - (2) Level 2 codes, which are procedure codes for which there are no CPT codes.
- (j) “Health care facility” means all facilities and institutions, as defined in Title 18 V.S.A. § 9402.
- (k) “Health care provider” means a person, partnership or corporation, other than a facility, as defined in Title 18 V.S.A. § 9402.
- (l) “Health insurer” means any health insurance company, nonprofit hospital and medical services corporation, health maintenance organization, and, to the extent permitted under federal law, any administrator of an insured, partially insured, self-insured or publicly funded health care benefit plan offered by public or private entities.
- (m) “ICD-9-CM codes” means the disease codes in the international classification of

diseases, 9th revision, clinical modification published by the United States Department of Health and Human Services.

- (n) “Local codes” means those codes approved for use by the State Uniform Claim Form Committee.
- (o) “Medicare” means Title XVIII of the federal Social Security Act.
- (p) “Pharmacy Products” means prescription drugs, durable medical equipment, surgical supplies and over-the-counter products when dispensed by a registered pharmacy.
- (q) “State Uniform Claim Form Committee” means the committee described in Section 10 of this regulation.

Section 5. HCFA-1500 Instructions.

- (a) Required users – All health care providers, other than dentists or pharmacists, whether they bill patients directly or file claims with insurers for services, must use the HCFA 1500 form.
- (b) Coding requirements – In addition to HCFA’s coding instructions, the following restrictions and conditions apply to the use of the HCFA-1500 form:
 - (1) An insurer may not require a health care provider to use any coding system other than the following:
 - a. HCPCS codes;
 - b. ICD-9-CM codes;
 - c. DSM-III-R codes (if an appropriate ICD-9-CM code does not exist);
 - d. local codes; and
 - e. any codes authorized by the State Uniform Claim Form Committee under Section 9(a)(2) of this regulation for use in unlabeled fields.

Section 6. HCFA-1450 Instructions.

- (a) All health care facilities shall use the HCFA-1450 form and conform to the National Uniform Billing Committee billing instruction manual for its use.
- (b) Coding requirements – An insurer may not require a health care provider to use any code other than the following:

- (1) ICD-9-CM;
 - (2) revenue codes;
 - (3) if charges for professional health care provider services are included, HCPCS codes;
 - (4) local codes; and
 - (5) a health care provider shall identify a patient using the unique patient identifier number designated in Section 9 of this regulation.
- (c) A hospital must use a HCFA-1500 form to supplement a HCFA-1450 form to bill patients or file claims for professional services.

Section 7. ADA Claim Form Instructions.

- (a) In order to bill patients directly and file claims with insurers for professional services as described in the CDT, a dentist or a corporation or partnership of dentists shall use the ADA claim form and follow the instructions for its use provided in the American Dental Association CDT user's manual.
- (b) An insurer may not require a dentist to use any code other than CDT codes.
- (c) A dentist shall identify a patient by using the unique patient identifier number designated in Section 9 of this regulation.

Section 8. Pharmacy Claim Instructions.

All pharmaceutical providers filing claims for pharmacy products shall use one or more of the following:

- (a) the electronic claims procedures endorsed by the National Council for Prescription Drug Programs; and/or
- (b) the universal claim forms endorsed by the National Council for Prescription Drug Programs.

Section 9. Use of Unique Identifiers.

- (a) Health care providers
 - (1) To complete any of the forms adopted under this regulation, health care providers shall use the unique identifier number or surrogate unique number assigned them by HCFA.

- (2) If the claim involves a billing organization, both the billing organization and the health care provider shall be identified. An organization shall be identified by its Federal Tax ID or a unique identifier assigned by an insurer.
 - (3) If a health care provider does not have a unique identifier number assigned by HCFA, the provider shall use his or her Vermont license or certification number, or other system recommended by the State Uniform Claim Form Committee and approved by the Commissioner.
 - (4) If a provider does not have an identifier as described in paragraph (c)(2) of this section and does not have a unique HCFA identifier, he or she shall use the generic identification number issued by an insurer.
- (b) Health care facilities.
- (1) To complete any of the forms adopted under this regulation, health care facilities shall use the facility identification number provided by HCFA or if no HCFA number exists, the unique identifier assigned by an insurer.
 - (2) Any attending health care provider shall be identified as described in subsection (a) of this section.
- (c) Patient numbers.
- (1) Patients shall be identified by their Social Security numbers or such other number designated by the Health Care Authority and approved for use by the Commissioner.

Section 10. State Uniform Claim Form Committee.

- (a) There is hereby established a State Uniform Claim Form Committee. The purpose of the Committee shall be:
- (1) the development of codes and regulation of their use;
 - (2) the regulation of unlabeled fields in the HCFA 1500, HCFA 1450 and ADA claim forms;
 - (3) to monitor the development of changes in national standards with respect to claim forms, electronic claim form formats, and procedures for the submission of both paper and electronic claim forms;
 - (4) to study and produce an annual report concerning the implementation of Electronic Data Interchange (EDI) in Vermont. In addition, the Committee shall review the efforts of the Workgroup for Electronic Data

Interchange (WEDI) and shall report to the Commissioner and the Health Care Authority Board regarding the adoption of WEDI standards for EDI in Vermont; and

- (5) to study issues and develop methods to otherwise improve the availability and consistency of health services information.
- (b) The initial Committee shall consist of the Commissioner, who shall act as chair of the Committee and one member of the Vermont Health Care Authority, who shall act as vice-chair of the Committee. In addition, the committee shall include one representative each from the hospital billing community, the non-hospital billing community, the dental billing community, the state Medicare intermediaries, a chain pharmacy store, the state Medicaid program and two representatives of health insurers, each of which shall serve two-year terms ending January 1.
- (c) The Committee shall make recommendations to the Commissioner regarding local codes and unlabeled fields that, upon approval of the Commissioner, shall be used by all health insurers and health care providers.

Section 11. General provisions.

- (a) A health care provider or institutional care provider shall file a claim in a manner consistent with the requirements of this regulation using either:
 - (1) a paper form printed on 8.5-inch paper; or
 - (2) an electronically-transmitted claim that is consistent with the procedure for submission of such claims as established by the State Uniform Claim Form Committee in conjunction with ANSI standards.
- (b) An issuer shall accept a form that is submitted in compliance with this regulation for the processing of an insured's claims.
- (c) Nothing in this regulation shall prevent an issuer from requesting additional information which is not contained on the forms required under this regulation to determine eligibility of the claim for payment.
- (d) All health care providers and institutional care providers shall:
 - (1) use the most current editions of the HCFA Form 1500, HCFA Form 1450, or ADA claim form and most current instructions for these forms in the billing of patients or their representatives and filing claims with issuers; and
 - (2) modify their billing practices to encompass the coding changes for all

billing and claim filing by the effective date of the changes set forth by the developers of the forms, codes and procedures required under this regulation.

- (e) To the extent that HCFA issues forms designed to replace HCFA-1450 or HCFA-1500, this regulation shall be deemed to have adopted any such replacement form or forms as of their issuance date and such forms shall be used by health care facilities and health care providers in compliance with all other provisions of this regulation.
- (f) To the extent that coding manuals are updated or revised, this regulation shall be deemed to have adopted such update or revision.