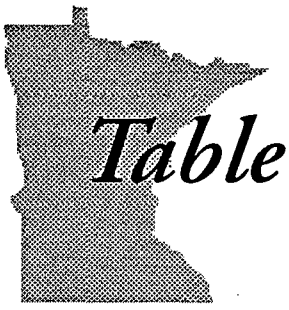
The Administrative Uniformity Committee

Final Recommendations Submitted to The Minnesota Department of Health and The Minnesota Health Care Commission

Februa

– Pursuant to 1994 Minn. Laws Chap. 625 Art. 9 Sec. 3 Subd. 3

– Pursuant to 1994 Minn. Laws Chap. 625 Art. 9 Sec. 3 Subd. 2



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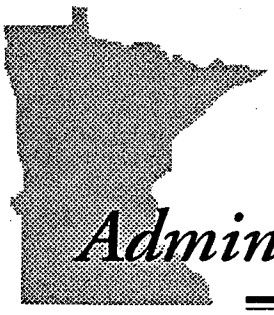

Administrative Uniformity Committee

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Abbott Northwestern	*Trisha Schirmers*
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Preface

Preface

1. The Administrative Uniformity Committee (AUC) recognizes implementation of the proposals for the use of the HCFA 1500 form and the UB92 and the ADA dental form will require significant system changes, impacting payors and providers alike. As a result, it has proposed a time table defining both voluntary compliance and mandatory implementation.

2. The recommendations for how to use the HCFA 1500 and UB92 billing forms acknowledge the specific requirements of Medicare, Medicaid and Workers Compensation that differ from the recommendations being proposed for Minnesota's payers and providers. We urge that these public programs, especially state programs, be asked to change their requirements wherever possible to match those recommended by the AUC.

Representatives from the Minnesota Departments of Human Services and Labor were active participants in developing the AUC recommendations. They could not commit those agencies to meeting the requirements since in many cases rulemaking or waivers would be needed to affect the necessary changes. The AUC asks for the support of the Commissioners of Health, Human Services and Labor and the Minnesota Legislature in achieving that goal.

Finally, the AUC is willing to contact the Uniform Claim Form Task Force which recommends Medicare policies and procedures regarding use of the HCFA 1500 and request consideration of changes in line with the recommended Minnesota standards.

3. The AUC acknowledges the difficulties raised by its recommendation to define the proper usage of billing formats based on whether services are offered by an institutional (e.g., hospital or SNF) or non-institutional-based organization, rather than by the type of services being provided. These recommendations are a reflection of the current Medicare guidelines for home care, ambulance, durable medical equipment, etc which require a UB92 if provided by a hospital, but a 1500 form if provided by a medical services company. The AUC plans continued discussion of this issue in 1994 (see #6 below).

4. The AUC proposes that the HCPCS (HCFA Common Procedural Coding System) Committee be asked to recommend additional coding for DME, physical therapy and home health care.

5. The AUC recommends that a professional trade association such as the Minnesota Medical Association or the Minnesota Medical Group Management Association accept responsibility for maintaining and distributing a manual for providers who need to use the HCFA 1500 form.

6. The AUC has identified other areas of inconsistency or confusion which it plans to address in 1994. This includes the following:

   - Coding and billing forms to be used by pharmacies, home health, DME and ambulance providers.

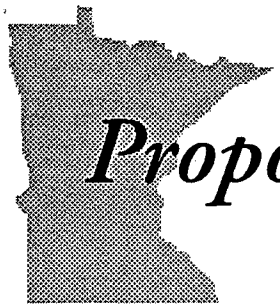
   - Measures or units to be reported on the UB92 and HCFA 1500.

   - Promotion and support for EDI.

   - Development of an ID card that would be promoted to payers and group purchasers.

   - Exploration of a single underwriting application form for small employers.

   - Serve as a resource to the Department of Health in implementing legislative and rulemaking initiatives that reflect our recommendations.



Proposal A

Services to be Billed on a UB92

The UB92 is proposed for the following services when they are provided by an institution/facility or by a company owned by an institution/facility. This includes hospitals, skilled nursing facilities, psychiatric inpatient facilities, and free standing ambulatory surgery centers, and Medicare certified home health agencies.

A. Institutional Inpatient Hospital Services and distinct units in the hospital such as:

Psychiatric Unit services
Physical Therapy Unit Services
Swing Bed (SNF) Services
Inpatient Skilled Nursing Facility Services
Home Health Services (Part A)
Hospice

B. Ancillary Services (Where benefits are exhausted or the patient has no Part A):

Hospital
State Psychiatric Hospital
Skilled Nursing Facility
Home Health (Part B)

C. Institutionally Owned/Operated Outpatient Services:

Hospital Outpatient services
- Ambulatory Surgical Center Services
- Hospital referred Laboratory Services
- Ambulance Services (Hospital Based or Under Arrangements)
- Other hospital outpatient

Skilled Nursing Facilities
Home Health, including infusion therapy
Free Standing Renal Dialysis Centers
Comprehensive Outpatient Rehabilitation Facilities (CORF)
Outpatient Rehabilitation Facilities (ORF)
Rural Health Clinics
Community Mental Health Center (CMHC)

Services to be Billed on a HCFA-1500 Form

(Service Definition: All independent/non-hospital based providers and services)

1. Physician services and supplies (a) (e)
2. DME Vendors (b)
3. Ambulance (c)
4. Ancillary Service Providers: (d)
   a. Occupational Therapists
   b. Physical Therapists
   c. Speech Therapists
   d. Audiologists
5. Podiatrists
6. Optometrists
7. Mental Health licensed professional services
8. Substance Abuse licensed professional services
9. Nursing Practitioner professional services
10. Certified Registered Nurse Anesthetists (CRNAs)
11. Chiropractors
12. Physician Assistants
13. Laboratories
14. Medical Suppliers (f)
15. Health Care (g)
    a. Home IV Therapy
    b. Personal Care Attendants (PCAs)
    c. Day Activity Centers
    d. Waivered Services
    e. Hospice
    f. Home Health Services
16. Ambulatory Surgical Centers

Definition and/or Outstanding Issues Requiring Further Review

a. Physician services refers to the professional services rendered or billed by the physician, on both an inpatient and outpatient environment.

b. Regarding DME Vendors, DHS would need to address with this proposal current internal procedures in order to comply. This includes enteral and perinatal nutritional suppliers.

c. Regarding ambulance charges, it was assumed that hospital-based ambulance providers would not submit separately on the HCFA-1500 Form, but would include those charges on the UB-92.

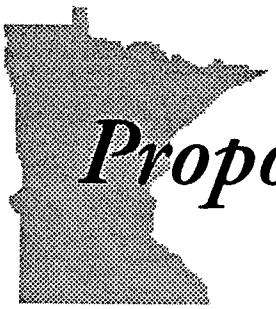
d. Ancillary services provided during a hospital visit confinement would be included on the UB-92 billing. However, for those independent providers of the OT/PT, Speech Therapy and Audiology, it was recommended that their professional services be billed on the HCFA-1500 Form. Rehab Agencies that also provide these ancillary services will submit bills on either the UB-92 or HCFA-1500, dependent on the licensing certifications.

e. Oral Surgeons would be included under "Physician services."

f. Medical Suppliers were added to the list to accommodate all other entities that would be billing for any type of supplies that are not included in the DME Vendor Category.

g. The Health Care category includes any Home IV Therapy providers (who bill for drugs, professional nursing services for the infusion therapy, and supplies), Personal Care Attendant (DHS coverage), Day Activity Centers (DHS coverage), and also Waivered Services (DHS covers the charges associated with adapting a residence to accommodate special needs).

* Workers Compensation and CHAMPUS billing requirements may not be consistent with the above proposal. Each must be reviewed to determine what steps would be needed to align those governmental programs with the proposed standards.



Proposal B

*UB92 Billing Form**

Recommendation #1: Mother/New Born Billing

BACKGROUND:

Payers currently require providers to use one of two methods to bill Mother and Newborn hospitalizations. Several payers require that Mother and Newborn claims be submitted on one UB92 using the mother's name as the patient, and the mother's diagnosis as the diagnosis. The name and diagnosis of the Newborn are therefore not reported. Other payers require they be submitted on two UB92's, as unique patients. Hospitals presently track Mother and Newborn as separate patients with individual medical records. The medical record is used to generate a bill for each patient. Requiring hospitals to combine the two bills into one is costly.

Positive aspects of billing separately for providers/payers:

1. Hospital administrative cost would be reduced.

2. Coordination of benefit administration for the providers and payers would be simplified.

3. Health plans cannot report consistent information for similar services if they do not receive comparable coding from providers. Separate bills would enable providers to report distinct mother and newborn data, such as diagnosis and procedures and multiple birth information to all payers.

Problems identified with billing separately for some payers:

1. Eligibility is difficult to determine for the newborn claims because membership files are not current.

2. Incorrect payment determination from separate bills can result in additional deductible and co-pay for the beneficiary.

3. Computer systems changes may be required for some payers.

4. Provider/payer contract currently stipulates combined billing for a mother and newborn.

**Note the updated UB92 replaced the current UB82 form in October, 1993.*

PROPOSAL:

That payers accept mother and newborn bills on separate UB92 hospital billing forms, following the National UB92 coding structure. Separate billing supports accurate data collection and allows hospitals one streamlined method of billing, thus, reducing administrative expenses.

IMPLEMENTATION:

The AUC recommends voluntary implementation by payers of the above proposal effective 1/1/94, with mandatory implementation by payers 7/1/95.

**Note the updated UB92 replaced the current UB82 form in October, 1993.*

*UB92 Billing Form**

Recommendation #2: Definition of Units

On the UB92, UNITS are reported in form locator 52/46 (a quantitative measure of services rendered). For any given service there can be as many definitions of UNITS as there are payers. In particular, significant inconsistencies have been identified by providers and payers with regard to outpatient services.

BACKGROUND:

Payers have required a variety of units to be reported. UNITS can mean minutes, hours, sessions, days, modalities, treatments, tests, miles, visits and pints depending upon the specific payer. Many discrepancies exist regarding which definition of a unit should be used for a given revenue code or type of service. The variability is greatest for outpatient rehabilitative services, such as: physical therapy, occupational therapy, speech therapy, mental health and chemical dependency services.

Examples of Variations:

- DHS is required by Federal regulations to define a UNIT by the time specified in the CPT code description.
- Medicare describes a UNIT as visits (regardless of time).
- Payer/Provider contracts require multiple definitions of UNITS.
- State legislation requires the number of hours of treatment for mental health and chemical dependency services.

Impact of Lack of Uniformity:

Payer perspective

- Itemizations of bills are requested to clarify services rendered.
- Increased administrative costs occur when staff review itemizations rather than have the system automatically process the bill.
- Benefits can be determined incorrectly if the services are not reported consistently.

**Note the updated UB92 replaced the current UB82 form in October, 1993.*

Provider perspective

- Maintenance of computer billing systems to handle multiple payer requirements is costly.
- Providing itemizations of bills increases administrative costs and delays cash flow.
- Manual intervention to alter the UNITS according to payer guidelines increases administrative costs.

PROPOSAL:

We recommend that payers and providers in the state of Minnesota reach agreement regarding how a unit is defined for services where the current diversity of definitions is creating confusion and additional costs. We acknowledge that Medicare's definition of a UNIT may be difficult to change. However, if the state's payers and DHS could adopt one standard definition, providers would have, at most, two methods for completing these sections of the UB92.

IMPLEMENTATION:

A task force of public and private payers and hospitals should be established to develop specific definitions for "UNITs" to be used on the UB92 Billing form. Task force recommendations should be presented to the AUC by October, 1994.

**Note the updated UB92 replaced the current UB82 form in October, 1993.*

*UB92 Billing Form**

Recommendation #3: Payers Requiring Claim Forms

Several payers require a copy of the claim form to be attached to the UB92 when it is submitted for payment.

BACKGROUND:

Commercial payers occasionally will not pay a claim unless an insurance company claim form signed by insured is submitted with the UB92 billing form. The information reported on the claim form is part of the beneficiary file at the insurance company. Some of the information reported on these forms are: employee demographics, patient demographics, accident or injury information, coordination of benefits information, authorization to release medical records and authorization to assign benefits. Providers routinely collect this information at the time of registration. Authorization to release medical records and to assign benefits are signed at registration, are included with provider signature forms and kept as part of patients records. It is common to provide a copy of those signatures during an audit. Providers consider it appropriate to request this type of information on per case basis rather than for each patient. Providers recognize it is important to include employment information and coordination of benefit information on the UB92 in the appropriate areas to ensure correct and fast payment, but believe it should be the responsibility of the insured to submit a claim form.

PROPOSAL:

1. Eliminate the requirement that providers submit insurance company claim forms along with the UB92.

2. Educate providers on complete and correct completion of patient coverage information on the UB92.

3. Place responsibility on the employer/payer to obtain employment and dependent information from the insured.

IMPLEMENTATION:

We recommend that voluntary implementation begin 1/1/94 with mandatory implementation by 7/1/95.

**Note the updated UB92 replaced the current UB82 form in October, 1993.*

*UB92 Billing Form**

Recommendation #4: Payers Require Itemizations

Claim payments are sometimes delayed when the itemization of charges are not submitted with the UB92.

BACKGROUND:

Several payers require a full itemization of charges submitted with the UB92 to satisfy often complex contractual requirements negotiated between providers and payers. Concern about the unreliability of coding on the UB92 affects payer ability to determine benefits. However, reliance on a detailed bill in addition to the UB92 creates a significant administrative expense and prohibits electronic transmission and electronic adjudication of the claim.

PROPOSAL:

1. Reduce requests/requirements for an attached detailed bill to be submitted in addition to the UB92. Exception: for Workers Compensation a detailed listing will continue to be provided.

2. Educate providers on the correct use of reporting tools: Revenue Codes, CPT/HCPCS codes, Diagnosis Codes, Procedure Codes, and Occurrence, Condition and Value codes.

3. Simplify contracts with payer/providers to eliminate the need for up front detail billing.

IMPLEMENTATION:

We recommend that voluntary implementation begin 1/1/94 and with renewal of payer/ provider contracts. Mandatory implementation would be required by 7/1/95.

**Note the updated UB92 replaced the current UB82 form in October, 1993.*

*UB92 Billing Form**

Recommendation #5: CPT-4/HCPCS Coding on the UB92

BACKGROUND

Some hospitals use CPT-4 or HCPCS coding for outpatient services, but many do not, substituting their own unique codes or relying on more general revenue codes. Payers desire the use of CPT-4 or HCPCS codes to ensure a consistent format for billing/paying for services that are delivered by other providers using HCFA 1500 forms and CPT-4/HCPCS coding. Payers note that these codes provide more specific information regarding the services provided. The newly revised UB92 form is designed to facilitate CPT-4/HCPCS codes in anticipation of this need.

PROPOSAL

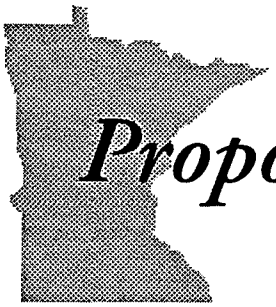
1. Institutions/facilities that use the UB92 form would use CPT-4/HCPCS codes for such outpatient services as diagnostic lab, x-ray, nuclear medicine, cardiac services, pulmonary functions, therapies, surgeries and home health care services. These codes would be provided in addition to the standard revenue and ICD-9 codes.

2. Educate institutions/facilities in the accurate and appropriate use of the codes.

IMPLEMENTATION

We recommend voluntary implementation by 1/1/94 with mandatory implementation by 1/1/95.

**Note the updated UB92 replaced the current UB82 form in October, 1993.*



Proposal C

HCFA 1500 PROPOSAL

Summary

In creating a proposed manual for the uniform use of the HCFA 1500 form, version (12-90), the Task Force focused on specific instruction rather than identifying differences among third party payors. Because no manual exists, we referenced information currently available in the Health Care industry. Participants on this Task Force included representatives from both the provider and payor communities.

Each page contains the item number and title as they appear on the 1500 form. Additionally, the format includes proposed instructions, current known exceptions, and proposed requirements. Rationales were included when necessary.

- "Proposed Instructions" is applicable for all payors additional clarification for government program payors is provided when necessary.

- "Current known exceptions" indicates Medicare, Medicaid or Workers Compensation requirements that differ from the proposed instructions.

- "Proposed Requirements" indicates whether the AUC proposes that providers submit and payors maintain and be able to transmit this information. An indication of "required" should be construed to mean "if applicable."

Implementation: The Administrative Uniformity Committee (AUC) proposed that this manual be adopted 1/1/94 to provide guidance to providers and payors. Over the following 18 months, the AUC will update the manual to include expected future agreements regarding universal identifiers for patients and providers and to clarify sections that prove confusing or ineffective for providers or payors. By 7/1/95, the AUC plans to propose a second draft of the manual to be adopted as mandatory for Minnesota providers and payors by 1/1/96.

HCFA 1500 PROPOSAL

Item Number 1
Health Insurance Coverage

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box for the type of health insurance coverage applicable to this claim. NOTE: Only 1 box indicating the payor who is to be billed should be checked.

CURRENT KNOWN EXCEPTIONS:

Workers' Compensation:

Requires that the name and address of the self-insured employer or workers' compensation payor be identified in the upper left corner of the form (above #1)

PROPOSED REQUIREMENT:

Required

RATIONALE:

To prepare for EDI standardization, this item will be necessary for use as a routing indicator.

HCFA 1500 PROPOSAL

Item Number 1a
Insured's I.D. Number

PROPOSED INSTRUCTIONS:

Enter the insured's* identification number as assigned by the payor to be billed. (Efforts underway at the national level to determine a universal patient identifier promise to lead to a standard approach).

Medicare Part B:

Enter the Medicare Health Insurance Claim Number (HICN) of the patient whether Medicare is the primary or secondary payor.

Medicaid:

Enter the patient's 8 digit Minnesota Health Program (MHP) I.D. number, exactly as it appears on the I.D. card.

Other Payors:

Enter the beneficiary number on the patient's ID card or, if unknown, the patient's social security number (SSN).

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

*insured means contract holder or subscriber in whose name the coverage is issued.

HCFA 1500 PROPOSAL

Item Number 2
Patient's Name

PROPOSED INSTRUCTIONS:

Enter the patient's last name, first name, and middle initial. If a family name suffix exists, enter the information with the last name first, suffix, first name and middle initial (Anderson, Jr., Edwin D.). Use the patient's name, whether or not the patient is the insured.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

Completion of this item coordinates efforts with the I.D. card task force to ensure uniformity.

HCFA 1500 PROPOSAL

Item Number 3
Patient's Birth Date/Gender

PROPOSED INSTRUCTIONS:

Enter the patient's date of birth and gender. The date of birth should appear in numeric format; for example, enter March 10, 1989 as "03 10 89". Place an "X" in either the box for "M" (male) or "F" (female).

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

To prepare for EDI standardization, this data should be kept in numeric format.

HCFA 1500 PROPOSAL

Item Number 4
Insured's Name

PROPOSED INSTRUCTIONS:

Entered the insured's last name, first name, and middle initial. If a family name suffix exists, enter the information as last name first, suffix, first name and middle initial. If the patient and the insured are the same, the word "Same" may be entered.
Example: Anderson, Jr., Edwin D.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 5
Patient's Address

Revision Date: February 14, 1994

PROPOSED INSTRUCTIONS:

Enter the patient's permanent mailing address, including the complete street name and number on the first line; the name of the city and the 2-letter state abbreviation on the second line; and zip code (9 digit preferred), phone number, if available, including area code, on the third line.

CURRENT KNOWN EXCEPTIONS:

Medicare Part B:

If indicating a change of address, place an "X" in front of the street address. (This enables identification of a change in address for those payors who utilize optical scanners).

PROPOSED REQUIREMENT:

Required

RATIONALE:

A 9 digit code is preferred because of lower mailing costs.

HCFA 1500 PROPOSAL

Item Number 6
Patient Relationship to the Insured

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box to indicate:

- "Self" -Patient is the insured
- "Spouse"-Patient is the insured's spouse
- "Child"-Patient is the insured's child
- "Other"-Patient is other than self, spouse, or child of the insured and is an eligible dependent under the policy

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 7
Insured's Address

PROPOSED INSTRUCTIONS:

Enter the insured's permanent mailing address, including the complete street name and number on the first line; the name of the city and the 2-letter state abbreviation on the second line; and the zip code (9 digit preferred), phone number, including area code, on the third line. If the address of the patient and insured are the same, the word "Same" should be entered.

CURRENT KNOWN EXCEPTIONS:

PROPOSED REQUIREMENT:

Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 8
Patient Status

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box to indicate the patient's marital status and employment or student status..

CURRENT KNOWN EXCEPTIONS:

Medicaid:

If the recipient is employed, enter an "X" in the box labeled Employed. No entry is required for the other boxes.

PROPOSED REQUIREMENT:

Required, if applicable

The Work Group questions the value and reliability of this data.

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 9
Other Insured's Name

PROPOSED INSTRUCTIONS:

Enter the last name, first name, and middle initial of the other insured. If a family name suffix exists, enter the information last name first, suffix, first name and middle initial (Anderson, Jr., Edwin D.) If there is no other insured, leave blank.

CURRENT KNOWN EXCEPTIONS:

Medicare Part B:

Enter the word "Same" if there is no other insured. If no Medigap benefits are assigned, leave blank.

Note: Item 9 is to be completed only if the patient is an enrollee in a Medigap policy and wishes to assign benefits under a Medigap policy to the provider, and only if the provider is a participating physician or supplier.

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

Completion of this item facilitates coordination of benefits.

HCFA 1500 PROPOSAL

Item Number 9a
Other Insured's Policy or Group Number

PROPOSED INSTRUCTIONS:

Enter the policy or group number of the other insured.

CURRENT KNOWN EXCEPTIONS:

Medicare Part B: Enter the policy and/or group number of the Medigap enrollee preceded by the word MEDIGAP.

Note: Item 9a is to be completed only if the patient is an enrollee in a Medigap policy and wishes to assign benefits under a Medigap policy to the provider, and only if the provider is a participating physician or supplier.

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

Completion of this item facilitates coordination of benefits.

HCFA 1500 PROPOSAL

Item Number 9b
Other Insured's Date of Birth/Gender

PROPOSED INSTRUCTIONS:

Enter the other insured's date of birth and gender in numeric format; for example, enter March 10, 1989 as "03 10 89". Place and "X" in either the box for "M" (male) or "F" (female).

CURRENT KNOWN EXCEPTIONS:

Medicare Part B:

If "Same" is entered in Item 9, leave blank.

PROPOSED REQUIREMENT:

Required, if 9a is completed.

RATIONALE:

Completion of this item facilitates coordination of benefits.

HCFA 1500 PROPOSAL

Item Number 9c
Employer's Name or School Name

PROPOSED INSTRUCTIONS:

Enter the employer or school name of the other insured.

CURRENT KNOWN EXCEPTIONS:

Medicare Part B:

Enter the claims processing address for the Medigap insurer. This item may be left blank if a carrier-assigned Unique Medigap Insurer Number (UMIN) appears in item 9d.

Note: Item 9c is to be completed only if the patient is an enrollee in a Medigap policy and wishes to assign benefits under a Medigap policy to the provider, and only if the provider is a participating physician or supplier.

Medicaid:

Enter the name of the policy holder's employer.

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

Completion of this item facilitates coordination of benefits.

HCFA 1500 PROPOSAL

Item Number 9d
Insurance Plan Name or Program Name

PROPOSED INSTRUCTIONS:

Enter the insurance plan or program name of the other insured.

CURRENT KNOWN EXCEPTIONS:

Medicare Part B:

> Enter the name of the Medigap enrollee's insurance company or the Medigap insurer's unique identifier (UMIN).

Note: Item 9d is to be completed only if the patient is an enrollee in a Medigap policy and wishes to assign benefits under a Medigap policy to the provider, and only if the provider is a participating physician or supplier.

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

Completion of this item facilitates coordination of benefits.

HCFA 1500 PROPOSAL

Item Number 10a
Is Patient's Condition Related to Employment? (Current of Previous)

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box to indicate whether employment applies to one or more of the services described in Item 24.

CURRENT KNOWN EXCEPTIONS: None

PROPOSED REQUIREMENT:

Required

RATIONALE:

Completion of this item facilitates determination of payor liability.

HCFA 1500 PROPOSAL

Item Number 10b
Is Patient's Condition Related to Auto Accident?

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box to indicate whether or not auto liability applies to one or more of the services described in Item 24.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

Completion of this item facilitates determination of payor liability.

HCFA 1500 PROPOSAL

Item Number 10c
Is Patient's Condition Related to an Accident other than Auto?

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box to indicate whether or not other accident involvement applies to one or more of the services described in Item 24.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

Completion of this item facilitates determination of payor liability.

HCFA 1500 PROPOSAL

Item Number 10d
Reserved for Local Use

PROPOSED INSTRUCTIONS:

Medicaid:

Medical transportation claims only: enter the number of people sharing the ride.

Medicare Part B:

Leave blank unless the patient is entitled to Medicaid. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by "MCD".

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 11
Insured's Policy, Group or FECA Number

PROPOSED INSTRUCTIONS:

Enter the insured's group number as it appears on the insured's ID card. Enter the word "None" if there is no other insurance coverage.

CURRENT KNOWN EXCEPTIONS:

Workers' Compensation:

Enter the workers' compensation payor's claim number.

Medicare Part B:

CLAIMS SUBMITTED WITHOUT COMPLETION OF THIS ITEM WILL BE DENIED

If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a - 11c.

If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12.

If there has been a change in the insured's insurance status, e.g., retired, enter the word "NONE" and proceed to item 11b.

Insured Primary to Medicare - Circumstances under which Medicare payment is secondary to other insurance include:

- Group Health Plan coverage

  - Working aged
  - Disability - large group health plan
  - End stage renal disease

- No fault and other liability

- Work-related illness/injury
  - Worker's Compensation
  - Black Lung
  - Veterans Administration

Whenever a claim is being filed to Medicare as a secondary payor, the Explanation of Benefits (EOB) from the primary payor must be attached to show the amount paid by the primary payor. In these instances, it is acceptable to attach the EOB to the HCFA-1500 claim form.

PROPOSED REQUIREMENT:

Required

RATIONALE:

Completion of this item facilitates determination of payor liability and it coordinates efforts with the I.D. card task force to ensure uniformity.

HCFA 1500 PROPOSAL

Item Number 11a
Insured's Date of Birth

PROPOSED INSTRUCTIONS:

Enter the insured's date of birth and gender if the patient is not the insured. The date of birth should appear in numeric format; for example: enter March 10, 1989 as "03 10 89". Place an "X" in either the box for "M" (male) or "F" (female).

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

Completion of this item facilitates determination of payor liability.

HCFA 1500 PROPOSAL

Item Number 11b
Employer's Name or School Name

PROPOSED INSTRUCTIONS:

Enter the name of the insured's employer or school.

Medicare Part B:

Enter the employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter the retirement date preceded by the word "RETIRED".

Medicaid:

Enter the name of the recipients employer.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

Completion of this item facilitates determination of payor liability.

HCFA 1500 PROPOSAL

Item Number 11c
Insurance Plan Name or Program Name

PROPOSED INSTRUCTIONS:

Enter the name of the insured's insurance plan or program.

Medicare Part B:

Enter the name of the state or geographic area where claims are to be submitted (Blue Cross Blue Shield of Wisconsin) for payors with multiple claims processing locations.

CURRENT KNOWN EXCEPTIONS:

Workers' Compensation:

Enter the name of the Worker's Compensation Managed Care Plan, if applicable.

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

Completion of this item facilitates determination of payor liability.

HCFA 1500 PROPOSAL

Item Number 11d
Is There Another Health Benefit Plan

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box to indicate whether or not there is another health benefit plan, if known.

If "Yes" has been indicated, complete items 9, 9a, 9b, 9c and 9d.

CURRENT KNOWN EXCEPTIONS:

Medicare Part B:

The Health Care Financing Administration (HCFA) directives state that Medicare Part B carriers are not to require this information.

PROPOSED REQUIREMENT:

Required.

The Work Group questions the necessity of this data since this information should be present in item 9, a-d.

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 12
Patient or Authorized Person's Signature

PROPOSED INSTRUCTIONS:

Enter the statement "Signature On File" or the patient's actual signature. If "Signature On File" is used, a release of medical record and assignment of benefits must be in the patient's chart.

CURRENT KNOWN EXCEPTIONS:

Most payors allow abbreviations, i.e., S.O.F.

PROPOSED REQUIREMENT:

Required

RATIONALE:

Completion of this item with "Signature On File" will facilitate uniformity between payors.

HCFA 1500 PROPOSAL

Item Number 13
Insured's or Authorized Person's Signature

PROPOSED INSTRUCTIONS:

Enter the statement "Signature On File" when payment is to be send directly to the provider. When payment is not to be sent directly to the provider, this item should be left blank.

CURRENT KNOWN EXCEPTIONS:

- Most payors allow abbreviations; i.e., S.O.F.
- Most payors allow this item to be left blank if a provider contract is on file.

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

Completion of this item with "Signature On File" will facilitate uniformity between payors.

HCFA 1500 PROPOSAL

Item Number 14
Date of Current Illness/Injury/Pregnancy (LMP)

PROPOSED INSTRUCTIONS:

Enter the date of the illness/injury/pregnancy (i.e., March 10, 1993 = 03 10 93)

CURRENT KNOWN EXCEPTIONS:

Medicare Part B:

- Enter the date of the injury if it is an accident-related MSP claim.
- For Chiropractic services, enter the date of the initiation of the course of treatment.

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

Completion of this item currently identifies only the accidental injury, not an illness or pregnancy. For policies that have a pre-existing clause, completion of this item facilitates correct claims processing.

HCFA 1500 PROPOSAL

Item Number 15
If Patient Has Had Same or Similar Illness

PROPOSED INSTRUCTIONS:

Enter the date the patient had the same or similar illness. Enter the date in numeric format; for example, enter March 10, 1989 as "03 10 89". If the recipient has not had the same or similar illness prior to this claim, leave blank.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

The Work Group questions the necessity of this item, since there is no practical application in the industry

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 16
Dates Patient Unable to Work in Current Occupation

PROPOSED INSTRUCTIONS:

Enter the first and last dates the patient was unable to work, if known. Enter the dates in numeric format; for example, enter January 1, 1991 through December 31, 1991 as From "01 01 91" To "12 31 91".

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 17
Name of Referring Physician or Other Source

PROPOSED INSTRUCTIONS:

Enter the name of the referring and/or ordering physician or other source if the patient:

1. Was referred to the performing physician for consultation or treatment.
2. Was referred to an entity, such as a clinical laboratory.
3. Obtained a physician's order for an item or service from an entity, such as a DME supplier.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 17a
I.D. Number of Referring Physician

PROPOSED INSTRUCTIONS:

Enter the HCFA assigned Unique Physician Identification Number (UPIN) of the referring or ordering physician. This item must be complete if item 17 has been completed.

When more than one UPIN is to be reported, providers must submit separate claim forms.

Identify any health care providers who do not possess UPINs. The billers should use a specified "surrogate number" and the health care provider's name and address and license or registration number on claims when the referring and/or ordering health care provider does not have a UPIN.

Surrogate UPINs:

INT - Interns
NPP - Nurse practitioner, clinical nurse specialists or any non-physician practitioner who is licensed by the state to order clinical diagnostic tests
OTH- Ordering/referring health care provider who has not been assigned a UPIN
PHS- Physicians serving on active duty in the military of the United States and those employed by the Department of Veterans Administration

Additional Note for Medicare Part B:

Services requiring this information may be delayed or denied if this item is not completed correctly.

This item must be completed if item 17 has been completed.

Medicaid:

Enter the referring physician's 9 digit MHP (Minnesota Health Program) provider number or a UPIN. Be sure to enter the individual's number and not the group number. If the referring physician is not an MHP provider, enter the provider name in box 17 and leave this box blank.

Workers' Compensation:

The referring provider must be identified by UPIN. If the provider does not have a UPIN, the degree, license or registration number must be entered. If the provider does not have a license or registration number, the name and degree of the provider must be provided.

PROPOSED REQUIREMENT:

Required, if applicable.

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 18
Hospitalization Dates Related to Current Services

PROPOSED INSTRUCTIONS:

Enter the dates of hospitalization.

Enter the dates in numeric format; for example, enter January 1, 1991 through January 5, 1991 as From "01 01 91" To "01 05 91".

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

The Work Group questions the necessity of this item since there is no practical application in the industry.

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 19
Reserved for Local Use

PROPOSED INSTRUCTIONS:

Medicare Part B:

Enter the date the patient was last seen and the Unique Physician Identification Number (UPIN) of the attending physician for a claim billed by an independent physical or occupational therapist, psychotherapist, or physician providing routine foot care. Enter the x-ray date for chiropractic services.

- Cardiac Pacemaker Monitoring - If billing for monitoring, enter the date of the pacemaker insertion.

- Chiropractor - Indicate if an x-ray was taken, "Y" = Yes, "N" - No. Is the x-ray available for review? "Y" = Yes, "N" = No. The date of the most current x-ray. Indicate if the condition is chronic = "CH". Indicate if the condition is a recurrence = "R" or exacerbation = "E". If so, also indicate the date of the occurrence = MM/DD/YY. Indicate the level of the subluxation if not accurately described by ICD-9 code.

  Example: YY 01/01/92 CH E 03/03/93 L2, L3

- MSP Liability - Enter the statement "patient fee/injured at home" to indicate patient was injured or fell on their own property and it is known there is no liability insurance which should pay primary.

- Podiatry - If applicable, also add the statement "acute inflammation/infection process and marked limitation of ambulation", or "acute inflammation/infection process and nonambulatory; condition will cause significant complications." You may abbreviate as necessary.

- Portion of Post-Op Care - Enter the statement "post-operative care assumed on __/__/__" or "post-operative care relinquished on __/__/__" whenever the post-operative out-of-hospital care is being split between two or more physicians. The overall charges made by all physicians must be pro-rated based upon the number of post-operative days for which each physician has responsibility.

- Therapy by an Independent Therapist - Enter the date the patient was last seen and the attending physician's UPIN.

Medicaid:

- Medical Transportation Claims - Enter the pick-up point and destination for this claim.

  For example: Pick-up point - 123 South St., St. Paul, MN
  Destination - Central Medical Center

Medicaid:

Mental Health Psychological Testing and Neuropsychological Assessment Services. when using the codes x5367 and 95883, list the name of each test administered in box 19. When possible use test abbreviations in common use.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 20
Outside Lab?

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box to indicate whether or not clinical diagnostic laboratory tests were performed in an outside laboratory.

If an "X" is placed in the "YES" box, enter the purchase price under "$ CHARGES."

If an "X" is placed in the "YES" box, item 32 must also be completed with the name, address and carrier assigned Provider Identification Number (PIN) of the clinical lab that performed the service.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

HCFA 1500 PROPOSAL

Item Number 21
Diagnosis or Nature of Illness or Injury

PROPOSED INSTRUCTIONS:

Enter up to four ICD-9-CM codes in order of priority. Relate items 1,2,3, or 4 to item 24E by line. Do not use decimal point. Do not provide narrative description.

Medicaid:

This box is required except for Medical Transportation and Vision Care (opticians, optometrists) claims.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 22
Medicaid Resubmission Code

PROPOSED INSTRUCTIONS:

Medicaid:

For Replacement Claims Only:

Enter the Replacement Reason Code if this is an adjustment to a previously paid claim, followed by the 17 digit transaction control number (TCN) assigned to the claims you want replaced. The TCN is entered under the title original referral number. Locate the TCN on the Remittance Advice (RA).

For Original Claims:

Leave blank.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 23
Prior Authorization Number

PROPOSED INSTRUCTIONS:

Enter the Prior Authorization Number as required by the individual payor.

Medicaid:

Use this box if the procedure required a PA, Home Care Service Agreement, Second Surgical Opinion (SSO), or pre-admission certification.

PA: Enter the 11 digit PA or Service Agreement number exactly as it appears on the PA or Service Agreement approval letter.

Certification/SSO: Enter the 10 digit number exactly as you receive it from the Medical Review Agent.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 24a
Date(s) of Service

PROPOSED INSTRUCTIONS:

Enter the month, day, and year for each procedure or supply in numeric format; for example, enter March 1, 1993 through march 31, 1993 as From "03 01 93" To "03 31 93".

If one date of service only, enter that date under "From".

If grouping services, the place of service, type of service, procedure code, charges and individual provider furnishing the services must be identical. Additionally, group only one calendar month of services per service line.

CURRENT KNOWN EXCEPTIONS:

Workers' Compensation:

Enter the individual date for each services billed. Services may not be grouped.

PROPOSED REQUIREMENT:

Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 24b
Place of Service

PROPOSED INSTRUCTIONS:

Enter the appropriate 2-digit place of service from the attached code and definition listing for each line procedure billed.

Medicare B:

> ***The place of service for laboratory tests should be reported based on where the test was performed. Suppliers using central billing operations must identify the office or sale/retail outlet location from which the services were furnished.***

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

Code & Definition Listing:

11 Office

Location, other than a hospital, Skilled Nursing Facility (SNF), Military Treatment Facility, Community Health Center, State or Local Public Health Clinic or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.

12 Patient's Home

Location, other than a hospital or other facility, where the patient receives care in a private residence.

13-20 (Unassigned)

21 Inpatient Hospital

A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by , or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 Outpatient Hospital

A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

23 Emergency Room - Hospital

A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24 Ambulatory Surgical Center

A freestanding facility, other than a physicians office, where surgical and diagnostic services are provided on an ambulatory basis.

25 Birthing Center

A facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis

26 Military Treatment Facility

A medical facility operated by one or more of the Uniformed Services. Miliary Treatment Facility (MTF) also refers to certain former U.S. Public Health service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

27-30 (Unassigned)

31 Skilled Nursing Facility

A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 Nursing Facility A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

33 Custodial Care Facility

A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34 Hospice A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

35-40 (Unassigned)

41 Ambulance - Land A land vehicle specifically designed, equipped and staffed for life-saving and transporting the sick or injured.

42 Ambulance Air or Water An air or water vehicle specifically designed, equipped and staffed for life-saving and transporting the sick or injured.

43-49 (Unassigned)

50 Federal Qualified Health Center

A facility located in a medically underserved area that provides Medicare beneficiaries preventative primary medical care under the general direction of a physician.

51 Inpatient Psychiatric Facility A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 Psychiatric Facility Partial Hospitalization A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible from outpatient visits in a hospital-based or hospital-affiliated facility.

53 Community Mental Health Center

A facility that provides the following services:

- Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility;

- 24 hour a day emergency care services;

- Day treatment, other partial hospitalization services, or psychosocial rehabilitation services;

- Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and

- Consultation and education services.

54 Intermediate Care Facility/Mentally Retarded A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

55 Residential Substance Abuse Treatment Facility A facility which provides treatment for substance (alcohol and drug) abuse to live-in resident who do not require acute, medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 Psychiatric Residential Treatment Center

A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

57-60 (Unassigned)

61 Comprehensive Inpatient Rehabilitation Facility

A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 Comprehensive Outpatient Rehabilitation Facility

A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

63-64 (Unassigned)

65 End Stage Renal Disease Treatment Facility

A facility other than a hospital, which provides dialysis treatment, maintenance and/or training to patients or care givers on an ambulatory or home-care basis.

66-70 (Unassigned)

71 State or Local Public Health Clinic

A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

73-80 (Unassigned)

81 Independent Laboratory

A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

82-98 (Unassigned)

99 Other Unlisted Facility

Other service facilities not identified above

HCFA 1500 PROPOSAL

Item Number 24c
Type of Service

PROPOSED INSTRUCTIONS:

Do not complete this item

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Not Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 24d
Procedures, Services, or Supplies

PROPOSED INSTRUCTIONS:

"CPT/HCPCS":

Enter the five character Physician Current Procedural Terminology (CPT) or HCFA Common Procedural Coding System (HCPCS) code that describes the procedure, service, or supply furnished to the patient. Refer to the CPT-4 and the HCPCS manual for code descriptions and directions, as applicable.

"MODIFIER":

Enter the two character CPT or HCPCS code, if applicable, that modifies or more fully describes the service performed. Up to three two-digit modifiers may be entered in this item. If more than three modifiers are needed, enter the fourth and subsequent modifier(s) in "24D" under "Modifier" for the next service line. No other information should be entered on this line.

Medicare Part B:

For anesthesia procedures, refer to instruction in 24G for correct submission of elapsed time.

Medicaid:

Modifier:

Enter up to two, 2 digit modifiers in this box. If more than two modifiers are required, enter a 99 in this box, instead of the required modifiers and attach and 8 1/2 x 11 sheet of paper indicating the modifiers.

Mental Health:

Psychological testing and neuropsychological assessment services (*5367 and 95883). If more than one test is administered on a date of services, use the modifier 76 in box 24D for the second test reported.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 24e
Diagnosis Code

PROPOSED INSTRUCTIONS:

Enter the Applicable number(s), 1-4 from item 21 that relate the diagnosis to the procedure. Up to four ICD-9-CM diagnosis code line numbers may be used to refer to each line item procedure.

If multiple reference numbers are required, do not use commas to separate.

The first number listed should be the primary diagnosis.

Medicaid:

This field is required on all claims except for Medica Transportation and Vision Care (opticians, optometrists) claims.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 24f
$ Charges

PROPOSED INSTRUCTIONS:

Enter the dollar amount charged for each listed services. If more than one unit or day is shown in Item 24G, the charge listed in 24F should reflect the total of all units being charged. If grouping services, the charges must be identical.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 24g
Days or Units

PROPOSED INSTRUCTIONS:

- Enter the units provided for each procedure or service. If only one service was performed, enter "1" in 24G.
- If the same procedure was performed on consecutive days, enter the total number of days. This number must correspond to the dates entered in 24A.
- If multiple services are provided, enter the actual number provided.
- For gas and liquid oxygen systems, suppliers must furnish the units of oxygen except for concentrators and initial rental claims.
- For anesthesia claims enter the actual anesthesia time in minutes; for example, enter one hour and fifteen minutes as "75."

CURRENT KNOWN EXCEPTIONS:

Medicaid:

For claims involving psychological testing and neuropsychological assessment services (x5367 and 95883) indicate the number of 15 minute units in 24G.

Workers' Compensation:

Services over multiple dates cannot be grouped together.

Private Payors:

Several have unique requirements, often specified in their contracts with providers.

PROPOSED REQUIREMENT:

Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 24h
EPSDT

PROPOSED INSTRUCTIONS:

Enter the dollar amount charged for each listed services. If more than one unit or day is shown in Item 24G, the charge listed in 24F should reflect the total of all units being charged. If grouping services, the charges must be identical.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 24i
EMG

PROPOSED INSTRUCTIONS:

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 24j
COB

PROPOSED INSTRUCTIONS:

Leave blank.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 24k
Reserved for Local Use

PROPOSED INSTRUCTIONS:

For government programs, indicate the professional who provided the service by the following means:

(Note: efforts underway at the national level to determine a universal provider identifier promise to lead to a standard approach.)

Medicaid:

Enter the individual Minnesota Health Program (MHP) Provider ID number or a UPIN.

Medicare Part B:

Enter the carrier-assigned Medicare Personal Identification Number (MPIN). Claims may be delayed or denied if this item is not completed.

Workers' Compensation

Enter the UPIN. If the provider does not have an assigned UPIN, enter the license or registration number. If none are available, enter the name and degree of the provider.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 25
Federal Tax ID Number

PROPOSED INSTRUCTIONS:

Enter the physician's/supplier's Federal Tax ID (Employer Identification Number or Social Security Number).

CURRENT KNOWN EXCEPTIONS:

None

Medicaid:

Not required

PROPOSED REQUIREMENT:

Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 26
Patient's Account Number

PROPOSED INSTRUCTIONS:

Enter the patient account number assigned by the physician/supplier

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 27
Accept Assignment?

PROPOSED INSTRUCTIONS:

Medicare Part B and CHAMPUS

Place an "X" in the "YES" box to indicate acceptance or the "NO" box to indicate non-acceptance.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 28
Total Charge

PROPOSED INSTRUCTIONS:

Enter the total charges for service on this billing statement. If multiple pages, enter the total on the last page only.

CURRENT KNOWN EXCEPTIONS:

Medicaid:

Requires that each page have a total.

PROPOSED REQUIREMENT:

Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 29
Amount Paid

PROPOSED INSTRUCTIONS:

Enter the total amount paid by the patient or another payor for the submitted charges in item 28.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required for Medicare Part B assigned claims and Medicaid, if applicable.

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 30
Balance Due

PROPOSED INSTRUCTIONS:

Enter the balance due for services included on this billing statement (item 28 less item 29)

CURRENT KNOWN EXCEPTIONS:

None

Medicaid:

Not required

PROPOSED REQUIREMENT:

Required for medicare Part B assigned claims.

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 31
Signature of Physician or Supplier Including Degrees or Credentials

PROPOSED INSTRUCTIONS:

Enter the signature of the physician/supplier or representative and the date the form was signed. A personal signature, computer generated signature, facsimile signature, signature stamp, or an authorized signature is acceptable.

CURRENT KNOWN EXCEPTIONS:

Medicaid:

DT&H (Day Training and Habilitation) claims require 2 signatures. The DAC vendor and an authorized representative of the ICF/MR must both sign the claim. Enter the first signature in this item. Enter the second signature in item 32.

PROPOSED REQUIREMENT:

Required

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 32
Name and Address of Facility where Services were Rendered

PROPOSED INSTRUCTIONS:

Enter the name and address of the person, organization or facility performing the service, if the services were furnished in a hospital, clinic, laboratory, or any facility other than the patient's home or physician's office. Enter the physician's practice address here, if different from item 33. Physicians must identify the suppliers name, address and carrier assigned Provider Identification Number (PIN) when billing for purchased diagnostic testes. Enter each name and carrier-assigned PIN when more than one supplier is used.

Enter the name of the facility if it is different form the provider's address when in item 33.

Enter the location where the order is accepted for durable medical equipment; for example, the site where the supplier or supplier's representative met with or received the beneficiary's call or order. Enter complete mailing address.

Enter the 10 digit HCFA-assigned certification number if the supplier is a certified mammography screening center.

CURRENT KNOWN EXCEPTIONS:

Medicaid:

DT&H (Day Training and Habilitation) Claims: Enter the second required signature in this item.

PROPOSED REQUIREMENT:

Required, if applicable

RATIONALE:

HCFA 1500 PROPOSAL

Item Number 33
Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number

PROPOSED INSTRUCTIONS:

Enter the following information (without punctuation)

Name of physician, clinic or supplier
Street address
City, state (2 letter abbreviation), zip code (9 digit preferred)
Provider Identification Number (PIN) # (if applicable), Group Insurer # (if applicable)

Medicare Part B:

Enter the carrier-assigned Group Identification Number

CURRENT KNOWN EXCEPTIONS:

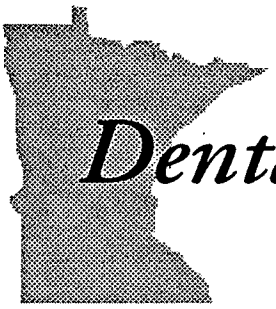
Medicaid:

GRP #: Enter the 9-digit Group Practice Minnesota Health Program Provider ID Number. If entering a group practice number, enter the individual 9 digit Minnesota Health Program Provider ID Number in item 24K for each line item. If entering an individual Minnesota Health Program Provider ID number, no entry in 24K is necessary.

PROPOSED REQUIREMENT:

Required

RATIONALE:



Dental ADA Form Instructions

Administrative Uniformity Committee
4-26-93 Version

ADA DENTAL PROPOSAL

Item Number a

Dentist Pretreatment Estimate or Dentist's State,emt of Actual Services

PROPOSED INSTRUCTION:

Place an "X" in the appropriate box. If this is a prior authorization request, put "X" in dentist's pretreatment estimate block.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number b

Carrier Name and Address

PROPOSED INSTRUCTIONS:

Enter appropriate payer's dental claims mailing address, city, state (2 letter abbreviation) and zip code plus 4 code.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 1

Patient's Name

PROPOSED INSTRUCTIONS:

Enter patient's first name, middle initial, last name.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 2

Patient Relationship to the Employee

ITEM TITLE:

Patient Relationship to the Employee.

PROPOSED INSTRUCTIONS:

Place an "X" in the box for "self" if the patient is the employee, "spouse" if the patient is the employee's husband or wife, apply "child" if the patient is the employee's child. If none of the above, place "X" to indicate "other" as applicable.

CURRENT KNOWN EXCEPTIONS:

If MA/GAMC/MinnesotaCare:

Leave blank.

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 3

Sex

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box to indicate the patient's sex.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 4

Patient's Birthdate

PROPOSED INSTRUCTIONS:

Enter the birthdate of the patient in the 8 digit numeric month, day and year format use all four digits for the year.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 5

Full Time Student if Over Age 18

PROPOSED INSTRUCTIONS:

If over age 18, place school (if college, use 3 letter initials in caps - if high school, use school name and HS) and city.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required If Applicable (◆)

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 6

Employee's Name and Mailing Address

PROPOSED INSTRUCTIONS:

Employee's first name, middle initial, and last name. The employee's mailing street address, city, state (2 letter abbreviation), and zip code.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 7

Employee's Social Security Number

PROPOSED INSTRUCTIONS:

Place employee's social security number (9 characters - do not use dashes or spaces).

CURRENT KNOWN EXCEPTIONS:

MA/GAMC/MinnesotaCare: Enter 9 digit recipient MA-ID.

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 8

Employee's Birthdate

PROPOSED INSTRUCTIONS:

Enter the employee's birthdate in the 8 digit numeric month, day and year format. Use 4 digits for the year. Do not use dashes or slashes.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 9

Employee's Employer's Name and Address

PROPOSED INSTRUCTIONS:

Name of employee's employer's name and mailing address, city, state (2 letter abbreviation) and zip code.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 10

Employee's (or Subscriber's) Group Number

PROPOSED INSTRUCTIONS:

Employee's (or subscriber's) group number exactly as presented on the patient's ID card.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 11

Is Patient Covered by Another Dental Plan Benefit?
Is Patient Covered by a Medical Plan?

PROPOSED INSTRUCTIONS:

Place "X" over appropriate answer, "yes" or "no". If there is other coverage, place "X" over "yes" and complete fields 12a - 15.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 12a

Name and Address of Other Dental Plan Carrier

INSTRUCTIONS:

Place name, city, state (2 letter initial) and zip plus 4 code reference in item for COB if applicable.

CURRENT EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required If Applicable.

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 12b

Other Dental Group Number

INSTRUCTIONS:

Place patient's group number exactly as presented on patient's ID card reference item 11 for COB if applicable.

CURRENT EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Mandatory If Applicable

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 13

Name and Address of Other Employer(s)

PROPOSED INSTRUCTIONS:

Place name of employer reference in item 11 for COB, city and state (2 letter abbreviation).

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required If Applicable

RATIONALE:

Item Number 14a

Employee/Subscriber Name (If Different Than Patient's)

PROPOSED INSTRUCTIONS:

Place employee's first name, middle initial and last name referenced in item 11 for COB if applicable.

CURRENT KNOWN EXCEPTIONS:

MA/GAMC, MinnesotaCare:

Enter the head of household

PROPOSED REQUIREMENT:

Required If Applicable

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 14b

Employee/Subscriber Social Security or ID Number

PROPOSED INSTRUCTIONS:

Place employee's social security number (9 characters - do not use dashes or spaces) referenced in item 11 for COB if applicable.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required If Applicable

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 14c

Employee/Subscriber Birthdate

PROPOSED INSTRUCTIONS:

Enter the employee's birthdate in the 8 digit numeric month, day and year format. Use 4 digits for the year. Do not use dashes or slashes.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required If Applicable

RATIONALE:

Item Number 15

Relationship to Patient

PROPOSED INSTRUCTIONS:

Place "X" in appropriate box referencing item 11.

CURRENT KNOWN EXCEPTIONS:

MA/GAMC/MinnesotaCare

Enter the relationship of the head of household to the recipient.

PROPOSED REQUIREMENT:

Required If Applicable

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 15a

Patient's Signature: I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand I am responsible for all costs of dental treatment.

ITEM TITLE:

PROPOSED INSTRUCTIONS:

If there is a signed release of information in the patient's file, you may default to "signature on file". Place the 6 digit numeric month, day and year format for date of signature.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 15b

Patient's Signature: I hereby authorize payment of the dental benefits directly to the dental entity.

PROPOSED INSTRUCTIONS:

If there is a signed release of information in the patient's file, you may default to "signature on file". Insured person include both the subscriber and the spouse.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 16

Dentist's Name

PROPOSED INSTRUCTIONS:

First name and last name of the dentist who provided the service (treating dentist).

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 17

Address Where Payment Should be Remitted

PROPOSED INSTRUCTIONS:

The mailing address, city, state (2 letter abbreviation) and zip plus 4 code.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

Item Number 18

Dentist Social Security Number of TIN

PROPOSED INSTRUCTIONS:

9 characters of the appropriate number based on tax status - do not use dashes or spaces.

CURRENT KNOWN EXCEPTIONS:

GA/GAMC/MinnesotaCare

Enter the clinic/individual MA ID number.

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 19

Dentist License Number

PROPOSED INSTRUCTIONS:

Place state numeric license number

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

Item Number 20

Dentist Telephone Number

PROPOSED INSTRUCTIONS:

Place phone number, including area code - do not use dashes or spaces.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 21

First Visit Date, Current Series

PROPOSED INSTRUCTIONS:

Place the 8 digit numeric month, day and year format - use all 4 digits for the year.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 22
Place of Treatment

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box. Valid places of services are: Office, hospital, ECF, other.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 23

Radiograph or Models Enclosed

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box, if "yes" indicate how many.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 24

Is Treatment Result of Occupational Illness or Injury?

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box, if "yes", explain.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 25

Is Treatment Result of Auto Accident?

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box, if "yes", indicate date of the accident in 6 digit numeric, month, day, year format and explain.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 26

Other Accident?

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box, if "yes", indicate date of the accident in 6 digit numeric, month, day, year format and explain.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 27

If Prosthesis, Is This Initial Placement?

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box, if "no", enter reason for replacement.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 28

Date of Prior Placement

PROPOSED INSTRUCTIONS:

If "28" yes, then list the 8 digit numeric date month, day, year format, use all four digits for the year.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 29

Is the Treatment for Orthodontics?

PROPOSED INSTRUCTIONS:

Place an "X" in the appropriate box, if yes, indicate date appliances placed (8 digit numeric date month, day, year format) (use 2 digits for the year) and months of treatment remaining.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 30a

Tooth Number or Letter

PROPOSED INSTRUCTIONS:

Submit CDT-1 codes by tooth in order from tooth number 1 through tooth number 32. Tooth letter A through T.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 30b

Surfaces

PROPOSED INSTRUCTIONS:

Enter tooth surfaces up to 4 surfaces per tooth, if applicable. Insert one abbreviation per column. Valid tooth surfaces and abbreviations are: Buccal (B), Distal (D), Facial (F), Incisal (I), Lingual (L), Mesial (M), Occlusal (O).

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 30c

Description of Service

PROPOSED INSTRUCTIONS:

Complete description of the procedure from CDT-1 code book.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 30d

Date(s) of Service

PROPOSED INSTRUCTIONS:

Enter the date the service was rendered (Use numeric month, day, year, use 2 digit year. For a pretreatment estimate, leave dates of service blank.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 30e

ADA Procedure Number

PROPOSED INSTRUCTIONS:

Enter specific ADA Procedure number based on CDT-1 (HCPCS) that describes the procedure.

CURRENT KNOWN EXCEPTIONS:

Medica accepts "00415" for infection control, which is not appropriate use of the CDT-1 code.

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 30f
Fee Charged

PROPOSED INSTRUCTIONS:

Fill in your usual and customary fee for each line on the claim. Use dollar and cents format, omit the dollar sign.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 30g

For Administrative Use Only

PROPOSED INSTRUCTIONS:

Leave Blank

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Not Applicable

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 30h
Total Fee Charged

PROPOSED INSTRUCTIONS:

Fill in the total of your usual and customary fees. Use dollar and cents format, omit the dollar sign.

CURRENT KNOWN EXCEPTION:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 30i
Total Plan Use

PROPOSED INSTRUCTIONS:

Leave Blank

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Not Applicable

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 31

Remarks for Unusual Service

PROPOSED INSTRUCTIONS:

Additional comments that support your request. If this is a MA/GAMC/ MinnesotaCare patient:

1. If this patient has been referred to you for services, indicate the MA provider ID number on the referring provider.
2. If the claim is a pretreatment, enter the 11 digit pretreatment number (numeric).
3. If the claim is a replacement claim, enter the replacement 3 digit reason code and 17 digit TCN of the original claim.
4. If the claim is a request for a pretreatment authorization, enter "Y" for retro or "N" for new and if retro, indicate appropriate 3 digit retro reason code.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required If Applicable

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 32a

Signature of Dentist

PROPOSED INSTRUCTIONS:

Place the signature of the provider of the service or enter "signature on file"

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 32b
License Number

PROPOSED INSTRUCTIONS:

Enter license number

CURRENT KNOWN EXCEPTIONS:

For MA/GAMC/MinnesotaCare enter the individual MA provider number of the treating provider.

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 32c
Date

PROPOSED INSTRUCTIONS:

Enter date, month, day year (8 digit numeric month, day, year.) Use 4 digits for year.

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Required

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 33

Maximum Allowable

PROPOSED INSTRUCTIONS:

Leave Blank

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Not Applicable

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 34
Deductible

PROPOSED INSTRUCTIONS:

Leave Blank

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Not Applicable

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 35

Carrier Percent

PROPOSED INSTRUCTIONS:

Leave Blank

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Not Applicable

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 36

Carrier Pays

PROPOSED INSTRUCTIONS:

Leave Blank

CURRENT KNOWN EXCEPTIONS:

For MA/GAMC/MinnesotaCare only; Enter any payment you have received from a third party carrier for these services to this recipient. Use dollar and cents format, omit the dollar sign.

PROPOSED REQUIREMENT:

Required If Applicable

RATIONALE:

ADA DENTAL PROPOSAL

Item Number 37

Patient Pays

PROPOSED INSTRUCTIONS:

Leave Blank

CURRENT KNOWN EXCEPTIONS:

None

PROPOSED REQUIREMENT:

Not Applicable

RATIONALE:

Appendix A

ADMINISTRATIVE UNIFORMITY COMMITTEE RECOMMENDATIONS TO THE MINNESOTACARE COMMISSION DECEMBER 15, 1992

Background

The Administrative Uniformity Committee (AUC) is a statewide, voluntary group representing public and private payors, hospitals, physicians and other healthcare providers. Its purpose is to develop concensus regarding uniform billing and other administrative policies and procedures that will reduce costs and improve the quality of health plan and provider administrative functions.

Assumptions and Operating Principles

Early in its deliberations, the committee identified several key principles to provide guidance for the committee's deliberations and a framework for three technical advisory groups chartered by the committee. The key principles are as follows:

1. Minnesota will adopt the UB82/92 and the HCFA 1500 form as the standard claims forms and ANSI standards.

2. Minnesota will adopt and implement uniform standards for health plan administration that are consistent with national efforts to achieve standardization.

3. The AUC recognizes that billing forms are one of several tools needed to accomplish the data reporting goals of MinnesotaCare; linkages with the Data Collection Advisory Group, the HealthCare Analysis Unit and other related groups will be essential to support the overall effort and minimize fragmentation without unnecessarily increasing costs and complexity.

4. Minnesota's initial efforts at uniformity will focus on claims for medical professionals and hospitals. To obtain the full benefits of standardization, however, we must ultimately expand our focus to include closely related information exchange such as eligibility and coverage verification, referral authorization, remittance advice, COB, electronic funds transfer and claims processes for other services such as dental and pharmacy.

Recommendations to the Commission

The AUC offers the following recommendations for improving the quality (accuracy, timeliness, completeness) and reducing the overall costs of public and private health plan administration. The recommendations are broad in scope and address changes that will take place over a period of years rather than months or weeks.

Recommendation #1

That the Commission and the State of Minnesota endorse the four key priniciples outlined above as a platform for achieving administrative uniformity.

Timeline: January 1993

Recommendation #2

That we reduce or eliminate the requirements for documentation in addition to that provided on the standard claims forms. For documentation judged to be essential, electronic transmission will be preferred.

Examples of additional documentation required by payors includes:

- clinical records such as ER reports, chart notes, lab reports, etc.
- detailed or itemized bill.
- claimant information forms.
- Explanation of Benefits (EOB) to support COB.
- consent forms.

Implementation Plan

2a. All public and private payors will be asked to evaluate what is being required now and how they voluntarily could change their policies, procedures, coding or contracts to eliminate or reduce the request for additional documentation.
Timeline: Publicize request to payors in February, 1993

2b. A new task force of public and private payors, providers and employers will evaluate the current situation, conduct surveys as needed and develop recommendations for reducing or eliminating the requirements for information that must accompany a standard claim. Minnesota Statute would also be reviewed.
Timeline: Complete study and recommendations by June, 1993

Recommendation #3

That we adopt uniform identifiers for patients and providers.

Implementation Plan

3a. The Electronic Data Interchange (EDI) technical advisory group will monitor progress onn the national WEDI plan to determine an approach to patient and provider identifiers (scheduled for October, 1993) and proactively seek to influence the outcome.
Timeline: Per WEDI schedule

3b. Once WEDI defines the approach, the AUC will develop an implementation plan for Minnesota consistent with the national plan (completion by the end of '95).
Timeline: Per WEDI schedule

Recommendation #4

That we develop a consistent format and terminology for patient ID cards. Provide basic information on all cards: payment source, patient identifier and key coverage information.

Implementation Plan

4a. The AUC and EDI Technical Advisor Group will monitor WEDI progress in developing recommendations for standardization of ID cards.
Timeline: May, 1993

4b. A new task force will evaluate the potential for piloting a model ID card for Minnesota use.
Timeline: October, 1993

Recommendation #5

A centralized database for licensed healthcare personnel is needed.

Implementation Plan

5a. The AUC requests that the Commission and the Department of Health consider how this could best be accomplished
Timeline: ?

Recommendation #6

That we develop concensus regarding the types of services and providers who should be reporting on each of the two claims forms; adopt a common set of data definitions for the fields of each form.

Implementation Plan

6a. The UB82/92 and HCFA 1500 Technical Advisory Groups will complete and disseminate recommendations by April, 1993 and, with sponsorship of the AUC, provide forums for discussio and feedback, revise as needed, and compile final recommendations.
Timeline: December, 1993

6b. The AUC and the advisory groups will provide information and education to providers, payors and purchasers to promote improvements in data quality and integrity.
Timeline: 1st Quarter, 1994

6c. Voluntary compliance with data definitions (Pilot Project).
Timeline: 2nd Quarter 1994-June, 1995

6d. Evaluate the results after the pilot, make adjustments and/or implement as required. Publicize the results nationally.
Timeline: July, 1995

Recommendation #7

That Minnesota payors, providers purchasers and policymakers should be active supporters of WEDI: monitoring progress, providing direct input to WEDI and ANSI work groups, adopting implementation plans that meet or exceed the timetables and goals for national implementation.

Implementation Plan for EDI Technical Advisory Group and AUC

7a. Develop a plan to educate providers, payors and purchasers regarding the benefits of Electronic Data Interchange (EDI) and current status, and gain support for activities needed to expand the use of EDI.
Timetable: March, 1993

7b. Establish priorities and timetables for implementation of EDI in Minnesota. Propose mandatory timelines for larger business and incentives to encourage smaller provider groups to participate.
Timeline: June, 1993

7c. Guide the AUC and Minnesota regarding opportunities to influence natinal efforts at standardization.
Timetable: 1993-1995