

OFFICE OF THE HEALTH INSURANCE COMMISSIONER
PROFESSIONAL PROVIDER HEALTH PLAN WORKGROUP
UNIFORM HEALTH PLAN CLAIM FORM REPORT

September 1, 2006

Statutory expectations §42-14.5-3

“To establish and provide guidance and assistance to a subcommittee (“The Professional Provider-Health Plan Work Group”) of the advisory council created pursuant to subsection (c) above, composed of health care providers and Rhode Island licensed Health Plans. This subcommittee shall develop a plan to implement the following activities:

(i) By January 1, 2006, a method whereby health plans shall disclose to contracted providers the fee schedules used to provide payment to those providers for services rendered to covered patients;

(ii) By April 1, 2006, a standardized provider application and credentials verification process, for the purpose of verifying professional qualifications of participating health care providers;

(iii) By September 1, 2006, a uniform health plan claim form to be utilized by participating providers;

(iv) By December 1, 2006, contractual disclosure to participating providers of the mechanisms for resolving health plan/provider disputes; and

(v) By February 1, 2007, a uniform process for confirming in real time patient insurance enrollment status, benefits coverage, including co-pays and deductibles.

This report focuses on activity (iii), the uniform health plan claim form.

Overview

The Professional Provider Health Plan Workgroup is comprised of professional provider and hospital representatives, billing agents, physician group leaders and the three major Rhode Island Health Plans: United, Blue Cross and Neighborhood Health Plan. The members are: Steve DeToy- RI Medical Society; Christopher Dooley- W&I PHO; Craig Syata-HARI; Lorraine Roberts- Lighthouse MD; Paul Carey-RI Urological Specialties; Joel Kaufman M.D.- Lifespan/Physicians PSO; Terri Tenny-RI Eye Institute; Michele DeRoche- New England Medical Billing; Kristen Santos- Care New England. Health Plan representatives are Robert Cambio- BCBS; Beverly Jane Perry- United; Paul Kaufman- United; Sin Mei Ko- Neighborhood Health Plan.

Discussion

After review, the workgroup agreed that this initiative lacked the specificity of the other initiatives previously addressed by this group. The group reviewed the intent of the statute language with one another and people familiar with the drafting process.

The CMS 1500 form is considered the industry standard claim form for use by professional providers nationally and is accepted by all payers in this market. All three local plans require the 1500 form as the standard for both paper and electronic claims.

Since the form itself is not an issue, the group instead evaluated claims- related concerns that may have been behind the statute language. It was identified that providers need to complete certain fields on the 1500 form slightly differently depending on the health plans' requirements and claims processing limitations. Code modifiers and non-billable codes were also identified as areas where there may be inconsistencies across plans. The group agreed to explore these issues further and discuss findings.

1. Problematic fields

The group discussed the specific fields on the 1500 form where there is inconsistency among the plans currently. Due to the implications for timely and accurate claims payment, none of the plans can make revisions to what data they require on the form. Each plan has unique software for claims logic and unbundling edits that effect how claims are paid. Although having detailed information regarding how a claim is adjudicated was identified as information the providers would find helpful, it was agreed this information is too complex to share in any uniform way. The plans are responsible for communicating this information to providers as necessary.

2. Modifiers and non billable codes

The health plans reported that they all universally apply modifiers as defined by the Current Procedural Technology (CPT) standards as defined by the American Medical Association.

None of the health plans was able to publish a list of codes defined as "non- billable" or "never paid" as they all reported that there might be exceptions due to self funded plans or case management requests.

3. The New CMS 1500 form

CMS has approved a modified 1500 form for use in 2007. All the plans reported that they have not yet done any programming for the new form, nor have they indicated to the provider community when they would begin to accept the new form. The plans agreed to keep the OHIC informed of their progress as they revise their systems to accommodate this change.

Findings

Compared to the fee schedule disclosure and common application initiatives that this group has worked on previously, the group found the uniform health plan claim form initiative to be less focused. The findings on this issue are as follows:

- For professional services the CMS 1500 form is considered the industry standard claim form. HIPAA further defines standards for electronic submission of this form. There are other administrative activities by health plans and providers where simplification and standardization would yield greater benefits.
- The information health plans require on the form varies slightly due to different claims processing systems. Since the logic of plans' claims systems are unique, complex and proprietary, it is not possible to standardize these form requirements short of reducing the number of health plans and payers in the system.
- Health plans should be expected to communicate their specific claims submission requirements including timing of updates based on CPT standards and overview of any claims editing logic to providers on a regular basis. This expectation could be articulated in the health plans/provider contract and communicated through the provider's sections of the plans' web site. The workgroup did not attempt to establish more specific standards for these communications.
- Providers for their part should be expected to stay abreast of these changes in claims logic, billing standards and coding terminology and update their billing processes to reflect them.
- The local health plans have agreed to keep the OHIC informed of any claims system changes that may result as the revised 1500 form becomes operational in 2007. In addition, OHIC will monitor the plans' claim processing trends under the new prompt processing regulations.