STEVEN T. FOSTER
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COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

November 16, 1995

ADMINISTRATIVE LETTER 1995-12

TO: ALL INSURERS, HEALTH SERVICES PLANS, AND HEALTH MAINTENANCE ORGANIZATIONS LICENSED TO WRITE ACCIDENT AND SICKNESS INSURANCE IN VIRGINIA

RE: Participation in the Primary Small Employer Market for Health Insurance in Virginia

Insurance Regulation No. 46 requires that, effective October 28, 1995, all Insurers, Health Services Plans and Health Maintenance Organizations (HMOs) transacting business with Primary Small Employers (2-25 eligible employees) be able to offer and make available to such Primary Small Employers an Essential Health Benefit Plan and a Standard Health Benefit Plan. These plans must be available on a policy form approved by the Virginia State Corporation Commission's Bureau of Insurance, as being in compliance with Article V, Chapter 34, Title 38.2 of the Code of Virginia, as well as with Insurance Regulation No. 46.

Insurers, Health Services Plans and HMOs that either have not registered to participate in the small employer market as required by § 38.2-3431.D.9.a of the Code of Virginia, or have not received approval of policy forms that provide an Essential Health Benefit Plan and a Standard Health Benefit Plan are prohibited from marketing health insurance to Primary Small Employers after October 28, 1995.

Many insurers who registered to participate in this market either have not filed policy forms or have filed them too late to have them approved by October 28. These insurers are encouraged to have the forms approved as promptly as possible so that they may participate in the Primary Small Employer market in Virginia. Insurers who have not notified the Bureau of Insurance of their intent to participate in or not participate in this market are reminded to do so immediately; and, if they elect to participate, to develop, file, and receive approval of Essential Health Benefit Plan and Standard Health Benefit Plan forms before transacting further business in this market.

Questions regarding this Administrative Letter should be directed to:

Robert L. Wright, III
Principal Insurance Analyst
State Corporation commission
Bureau of Insurance - Life and Health Division
Post Office Box 1157
Richmond, VA 23218
Telephone: (804) 371-9586 FAX: (804) 371-9944

Yours truly,

Steven T. Foster
Commissioner of Insurance

STF/tlf

DISKETTE REQUEST FORM

Catherine S. West
Microcomputer Systems Coordinator
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23209

RE: Administrative Letter 1995-3
Annual Report of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers Pursuant to Section 38.2-3419.1 of the Code of Virginia and Regulation No. 38

Dear Ms. West:

We would like to submit the above-referenced report for the 1994 reporting period on computer diskette using the entry system supplied by the Bureau of Insurance (requiring an IBM or IBM compatible personal computer with DOS and a minimum of 640K of memory). Please forward a:

- ☐ 3.5" high density (1.4M) diskette
- ☐ 5.25" high density (1.2M) diskette

containing Form MB-1, the required data entry system, and instructions to my attention as indicated below. **I understand that the Bureau's data entry system which I am requesting is not compatible with Windows.**

Name: _____

Title: _____

Company: _____

NAIC Number: _____ Group NAIC Number: _____

Mailing Address: _____

_____

_____

Phone Number: _____

Date: _____

B. Form MB-1

Form MB-1

Annual Report of Cost and Utilization Data
Relating to Mandated Benefits and Mandated Providers
Pursuant to § 38.2-3419.1 of the Code of Virginia

Reporting Period _____

Company Name _____

Group Name _____

Mailing Address _____

_____

NAIC#_____ Group NAIC #_____

Name of Person Completing Report _____

Title_____

Direct Telephone #_____

Mailing Address_____

_____

Total accident and sickness premiums written in Virginia for all accident and sickness lines including credit, disability income, and all others, whether subject to §§ 38.2-3408 or 38.2-4221 and §§ 38.2-3409 through 38.2-3419 of the Code of Virginia or not, as reported on the Company's Annual Statement for the reporting period: $_____

Total accident and sickness premiums written in Virginia on applicable policies and contracts, as defined in § 3 of these rules that are subject to §§ 38.2-3408 or 38.2-4221 and §§ 38.2-3409 through 38.2-3419 for the reporting period: $_____

Does this company claim eligibility to file an abbreviated report under § 4 C of Regulation No. 38 for this reporting period?

[ ] Yes, and filing the abbreviated report allowed for in § 4 C.

[ ] No, and filing a complete report.

Part A: Claim Information - Benefits*

Enter the basis on which claim data presented throughout this report was collected (either "paid" or "incurred"): [ ]

INDIVIDUAL

Va. Code Section	Description	a Number of Visits	b Number of Days	c Total Claims Payments	d Number of Contracts	e Claim Cost Per Contract	f Annual Administrative Cost	g Percent of Total Health Claims
38.2-3409	Dependent Children (Handicapped)							
38.2-3410	Doctor to Include Dentist							
38.2-3411	Newborn Children							
38.2-3412.1	Mental / Emotional / Nervous							
	Inpatient							
	Partial Hospital.							
38.2-3412.1	Alcohol and Drug Dependence							
	Inpatient							
	Partial Hospital.							
38.2-3418	Pregnancy from Rape/ Incest							
38.2-3418.1	Mammography							
38.2-3411.1	Child Health Supervision							

Enter total claims paid or incurred on individual policies subject to the above requirements (this figure should be used in calculating the figures required for column g): [ ]

* include information and amounts paid or incurred on hospital bills and other providers

a: number of provider and physician visits

b: number of inpatient or partial hospital days (if applicable)

c: total of claims paid or incurred for this mandate

d: number of contracts in force in Virginia containing the required or optional coverage

e: claim cost per contract = column c divided by column d

f: the administrative cost of complying with this mandate during the reporting period

g: claims paid or incurred for this benefit as a percentage of the total amount of health claims paid or incurred on individual policies or contracts subject to this reporting requirement

GROUP Va. Code Section	Description	a Number of Visits	b Number of Days	c Total Claims Payments	d Number of Certificates	e Claim Cost Per Certificate	f Annual Administrative Cost	g Percent of Total Health Claims
38.2-3409	Dependent Children (Handicapped)							
38.2-3410	Doctor to Include Dentist							
38.2-3411	Newborn Children							
38.2-3412.1	Mental / Emotional / Nervous:							
	Inpatient							
	Partial Hospital.							
	Outpatient							
38.2-3412.1	Alcohol and Drug Dependence							
	Inpatient							
	Partial Hospital.							
	Outpatient							
38.2-3414	Obstetrical Services							
	Normal Pregnancy							
	All Other							
38.2-3418	Pregnancy from Rape / Incest							
38.2-3418.1	Mammography							
38.2-3411.1	Child Health Supervision							

Enter total claims paid or incurred on group policies that are subject to the above requirements (this figure should be used in calculating the figures required for column g): ☐

* include information and amounts paid or incurred on hospital bills and other providers for all health care expenses incurred because of this mandate

a: number of provider and physician visits

b: number of inpatient or partial hospital days (if applicable)

c: total of claims paid or incurred for this mandate

d: number of certificates containing the required or optional coverage

e: claim cost per certificate = column c divided by column d

f: the administrative cost of complying with this mandate during the reporting period

g: claims paid or incurred for this benefit as a percentage of the total amount of health claims paid or incurred on group policies or contracts subject to this reporting requirement

Part B: Claim Information - Providers

INDIVIDUAL

Va. Code Sections 38.2-3408 & 38.2-4221	a Number of Visits	b Total Claims Payments	c Cost Per Visit	d Number of Contracts	e Claim Cost Per Contract	f Annual Administrative Cost	g Percent of Total Health Claims
Chiropractor							
Optometrist							
Optician							
Psychologist							
Clinical Social Worker							
Podiatrist							
Professional Counselor							
Physical Therapist							
Clinical Nurse Specialist*							
Audiologist							
Speech Pathologist							

* rendering mental health services

a: number of visits to this provider group for which claims were paid or incurred in Virginia
b: total dollar amount of claims paid to this provider group in Virginia
c: cost per visit = column b divided by column a
d: number of individual contracts subject to this reporting requirement
e: claim cost per contract = column b divided by column d
f: the administrative cost of complying with this mandate during the reporting period
g: claims paid or incurred for services administered by each provider type as a percentage of the total amount of health claims paid or incurred on individual policies or contracts subject to this reporting requirement

GROUP

Va. Code Sections 38.2-3408 & 38.2-4221	a Number of Visits	b Total Claims Payments	c Cost Per Visit	d Number of Certificates	e Claim Cost Per Certificate	f Annual Administrative Cost	g Percent of Total Health Claims
Chiropractor							
Optometrist							
Optician							
Psychologist							
Clinical Social Worker							
Podiatrist							
Professional Counselor							
Physical Therapist							
Clinical Nurse Specialist*							
Audiologist							
Speech Pathologist							

* rendering mental health services

a: number of visits to this provider group for which claims were paid or incurred in Virginia
b: total dollar amount of claims paid to this provider group in Virginia
c: cost per visit = column b divided by column a
d: number of certificates subject to this reporting requirement
e: claim cost per certificate = column b divided by column d
f: the administrative cost of complying with this mandate during the reporting period
g: claims paid or incurred for services administered by each provider type as a percentage of the total amount of health claims paid or incurred on group contracts subject to this reporting requirement

Part C: Premium Information

1. Please use what you consider to be your standard policy to answer this question. For the individual policy used as your base calculations in the question below:

- o What is the deductible? _____
- o What is the coinsurance? _____
- o What is the individual/employee out-of-pocket maximum? _____

For the group policy used as your base calculation in the question below:

- o What is the deductible? _____
- o What is the coinsurance? _____
- o What is the individual/employee out-of-pocket maximum? _____

For your standard health insurance policy in Virginia, provide the total annual premium that would be charged per unit of coverage assuming inclusion of all of the benefits and providers listed below. In addition, provide the portion (dollar amount) of the annual premium for each policy that is attributable to each mandate listed. If the company does not have a "Family" rating category, coverage for two adults and two children is to be used when calculating the required family premium figures.

Please indicate where coverage under your policy exceeds Virginia's mandates.

	Va. Code Section	Individual Policy		Group Certificates	
		Single	Family	Single	Family
Annual Premium for Standard Policy Described Above		_____	_____	_____	_____
Premium Attributable to Each Mandate:					
Dependent Children (Handicapped)	38.2-3409		_____		_____
Doctor to Include Dentist	38.2-3410	_____	_____	_____	_____
Newborn Children	38.2-3411		_____		_____
Mental/Emotional/Nervous (Mental Disabilities)	38.2-3412.1				
Inpatient		_____	_____	_____	_____
Partial Hospitalization		_____	_____	_____	_____
Outpatient				_____	_____

Alcohol and Drug Dependence	38.2-3412.1				
Inpatient		_____	_____	_____	_____
Partial Hospitalization		_____	_____	_____	_____
Outpatient				_____	_____
*Obstetrical Services	38.2-3414				
Normal Pregnancy				_____	_____
All Other				_____	_____
Pregnancy from Rape or Incest	38.2-3418	_____	_____	_____	_____
*Mammography	38.2-3418.1	_____	_____	_____	_____
*Child Health Supervision	38.2-3411.1	_____	_____	_____	_____

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* Denotes mandated offer

Chiropractor	38.2-3408/38.2-4221	_____	_____	_____	_____
Optometrist	38.2-3408/38.2-4221	_____	_____	_____	_____
Optician	38.2-3408/38.2-4221	_____	_____	_____	_____
Psychologist	38.2-3408/38.2-4221	_____	_____	_____	_____
Clinical Social Worker	38.2-3408/38.2-4221	_____	_____	_____	_____
Podiatrist	38.2-3408/38.2-4221	_____	_____	_____	_____
Professional Counselor	38.2-3408/38.2-4221	_____	_____	_____	_____
Physical Therapist	38.2-3408/38.2-4221	_____	_____	_____	_____
Clinical Nurse Specialist**	38.2-3408/38.2-4221	_____	_____	_____	_____
Audiologist	38.2-3408/38.2-4221	_____	_____	_____	_____
Speech Pathologist	38.2-3408/38.2-4221	_____	_____	_____	_____

** rendering mental health services

2. What is the number of individual policies and/or group certificates issued or renewed by the Company in Virginia during the reporting period?

	Single	Family
Individual	_____	_____
Group	_____	_____

3. What is the number of individual policies and/or group certificates in force for your company in Virginia as of the last day of the reporting period?

	Single	Family
Individual	_____	_____
Group	_____	_____

4. What would be the annual premium for an individual policy with no mandated benefits or mandated providers for a 30 year old male in the Richmond area in your standard premium class? What would be the cost for a policy for the same individual with present mandates? (Assume coverage including $250 deductible, $1,000 stop-loss limit, 80% co-insurance factor, $250,000 policy maximum.) If you do not issue a policy of this type, please provide the premium for a 30 year old male in your standard premium class for the policy that you offer that is most similar to the one described and summarize the differences from the described policy.

Without Mandates $_____

With Mandates $_____

Differences in Policy _____
_____
_____
_____

5. The following questions concern the cost of converting group coverage to an individual policy. Answer only those questions which are relevant to your company's practices.

a. If the company adds an amount to the annual premium of a group policy or certificate to cover the cost of conversion to an individual policy, provide the average dollar amount per certificate:

Single: _____ Family: _____

b. If the cost of conversion is instead covered in the annual premium of the individual policy, provide the average dollar amount attributable to the conversion requirement:

Single: _____ Family: _____

c. If the cost of conversion is instead covered by a onetime charge made to the group policyholder for each conversion, provide the average dollar amount:

Single: _____ Family: _____

Part D: Utilization and Expenditures for Selected Procedures by Provider Type

Selected Procedure Codes are listed here to obtain information about utilization and costs for specific types of services. Please identify expenditures and visits for the Procedure Codes indicated. Other claims should not be included here. Individual and group data must be combined for this part of the report.

1. **Procedure Code 99203**
   Office Visit, Intermediate Service to New Patient

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Clinical Social Worker			
Physical Therapist			
Podiatrist			
Professional Counselor			
Psychologist			
Physician			

2. **Procedure Code 90844**
   Medical Psychotherapy, 45 to 50 Minute Session

	Number of Visits	Claims Payments	Cost Per Visit
Clinical Nurse Specialist*			
Clinical Social Worker			
Professional Counselor			
Psychiatrist			
Psychologist			
Physician			

3. **Procedure Code 90853**
   Group Medical Psychotherapy

	Number of Visits	Claims Payments	Cost Per Visit
Clinical Nurse Specialist*			
Clinical Social Worker			
Professional Counselor			
Psychiatrist			
Psychologist			
Physician			

* rendering mental health services

4. **Procedure Code 92507**
Speech, Language or Hearing Therapy; Individual

	Number of Visits	Claims Payments	Cost Per Visit
Audiologist			
Clinical Social Worker			
Physical Therapist			
Professional Counselor			
Speech Pathologist			
Physician			

5. **Procedure Code 97110**
Physical Medicine Treatment, 30 Minutes, Therapeutic Exercise

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			
Speech Pathologist			

6. **Procedure Code 97124**
Physical Medicine Treatment, Massage

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			

7. **Procedure Code 97128**
Physical Medicine Treatment, Ultrasound

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			

8. **Procedure Code 92352**
Fitting of Spectacle Prosthesis for Aphakia, monofocal

	Number of Visits	Claims Payments	Cost Per Visit
Ophthalmologist			
Optician			
Optometrist			
Physician			

9. **Procedure Code 11750**
Excision of Nail and Nail Matrix, Partial or Complete, for Permanent Removal

	Number of Visits	Claims Payments	Cost Per Visit
Physician			
Podiatrist			

Appendix B. CPT-4, ICD-9CM, and UB-82 References.

A. CPT and ICD-9CM Codes

Va. Code Section 38.2-3410: Doctor to Include Dentist
(Medical services legally rendered by dentists and covered under contracts other than dental)

ICD Codes

520-529	Diseases of oral cavity, salivary glands and jaws

Va. Code Section 38.2-3411: Newborn Children
(children less than 32 days old)

ICD Codes

740-759	Congenital anomalies
760-763	Maternal causes of perinatal morbidity and mortality
764-779	Other conditions originating in the perinatal period

CPT Codes

99295	Initial NICU care, per day, for the evaluation and management of a critically ill neonate or infant
99296	Subsequent NICU care, per day, for the evaluation and management of a critically ill and unstable neonate or infant
99297	Subsequent NICU care, per day, for the evaluation and management of a critically ill and stable neonate or infant
99431	History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records
99432	Normal newborn care in other than hospital or birthing room setting including physical examination of baby and conference(s) with parent(s)
99433	Subsequent hospital care for the evaluation and management of a normal newborn, per day

99440	Newborn resuscitation: care of the high risk newborn at delivery, including, for example, inhalation therapy, aspiration, administration of medication for initial stabilization

Va. Code Section 38.2-3412.1: Mental/Emotional/Nervous Disorders
(must use UB-82 place-of-service codes from Section B of this Appendix to differentiate between inpatient, partial hospitalization, and outpatient claims where necessary)

ICD Codes

290, 293-294	Organic Psychotic Conditions
295-299	Other psychoses
300-302, 306-316	Neurotic disorders, personality disorders, other non-psychotic mental disorders
317-319	Mental retardation

CPT Codes

99221-99223	Initial hospital care, per day, for the evaluation and management of a patient
99231-99233	Subsequent hospital care, per day, for the evaluation and management of a patient
99238	Hospital discharge day management
99241-99263	Consultation for psychiatric evaluation of a patient includes examination of a patient and exchange of information with primary physician and other informants such as nurses or family members, and preparation of report.
90801	Psychiatric diagnostic interview examination, including history, mental status, or disposition
90820	Interactive medical psychiatric diagnostic interview examination
90825	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes
90830	Psychological testing by physician, with written report per hour

90835	Narcosynthesis for psychiatric diagnostic and therapeutic purposes
90841	Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy; time unspecified
90842	approximately 75 to 80 minutes (90841)
90843	approximately 20 to 30 minutes (90841)
90844	approximately 45 to 50 minutes (90841)
90845	Medical psychoanalysis
90846	Family medical psychotherapy (without the patient present)
90847	Family medical psychotherapy (conjoint psychotherapy) by a physician, with continuing medical diagnostic evaluation, and drug management when indicated
90849	Multiple family group medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated
90853	Group medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated
90855	Interactive individual medical psychotherapy
90857	Interactive group medical psychotherapy
90862	Pharmacologic management, including prescription use, and review of medication with no more than minimal medical psychotherapy
90870	Electro convulsive therapy, single seizure
90871	Multiple seizures, per day
	Other Psychiatric Therapy
90880	Medical hypnotherapy
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions

90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them to assist patient
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers
	Other Procedures
90899	Unlisted psychiatric service/procedure

Va. Code Section 38.2-3412.1: Alcohol and Drug Dependence

ICD Codes

291	Alcohol Psychoses
303	Alcohol dependence syndrome
292	Drug Psychoses
304	Drug dependence
305	Nondependent abuse of drugs

CPT Codes

Same as listed above for Mental/Emotional/Nervous Disorders, but for above listed conditions.

Va. Code Section 38.2-3414: Obstetrical Services

Normal Pregnancy

ICD Codes

650	Normal delivery without abnormality or complication classifiable elsewhere in categories 630-676, and with spontaneous cephalic delivery, without mention of fetal manipulation or instrumentation

CPT Codes

Any codes in the maternity care and delivery range of 59000-59899 associated with ICD Code 650 listed above

All Other Obstetrical Services

ICD Codes

630-648, 651-676	Complications of pregnancy, childbirth, and puerperium

CPT Codes

Incision, Excision, Introduction, and Repair

59000	Amniocentesis, any method
59012	Cordocentesis (intrauterine), any method
59015	Chorionic villus sampling, any method
59020	Fetal contraction stress test
59025	Fetal scalp blood sampling
59050	Initiation and/or supervision of internal monitoring during labor by consultant with report (separate procedure)
59100	Hysterotomy, abdominal (e.g., for hydatidiform mole, abortion)
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach
59121	tubal or ovarian, without salpingectomy and/or oophorectomy (59120)
59130	abdominal pregnancy (59120)
59135	interstitial, uterine pregnancy requiring total hysterectomy (59120)
59136	interstitial, uterine pregnancy with partial resection of uterus (59120)
59140	cervical, with evacuation (59120)

59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy
59151	with salpingectomy and/or oophorectomy (59150)
59160	Curettage, postpartum (separate procedure)
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)
59300	Episiotomy or vaginal repair, by other than attending physician
59320	Cerclage or cervix, during pregnancy; vaginal
59325	abdominal (59320)
59350	Hysterorrhaphy of ruptured uterus

Delivery, Antepartum and Postpartum Care

59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59410	including postpartum care (59409)
59412	External cephalic version, with or without tocolysis
59414	Delivery of placenta following delivery of infant outside of hospital
59425	Antepartum care only; 4-6 visits
59426	7 or more visits (59425)
59430	Postpartum care only (separate procedure)

Cesarean Delivery

59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59514	Cesarean delivery only
59515	including postpartum care (59514)

59525	Subtotal or total hysterectomy after cesarean delivery (list in addition to 59510 or 59515)

Abortion

99201-99233	Medical treatment of spontaneous complete abortion, any trimester
59812	Treatment of incomplete abortion, any trimester, completed surgically
59820	Treatment of missed abortion, completed surgically, first trimester
59821	second trimester (59820)
59830	Treatment of septic abortion, completed surgically
59840	Induced abortion, by dilation and curettage
59841	Induced abortion, by dilation and evacuation
59850	Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines);
59851	with dilation and curettage and/or evacuation (59850)
59852	with hysterotomy (failed intra-amniotic injection) (59850)

Other Procedures

59870	Uterine evacuation and curettage for hydatidiform mole
59899	Unlisted procedure, maternity care and delivery

Anesthesia

00850	Cesarean
00855	Cesarean hysterectomy
00857	Continuous epidural analgesia for labor and cesarean section

Va. Code Section 38.2-3418: Pregnancy from Rape/Incest

Same Codes as Obstetrical Services/Any Other Appropriate in cases where coverage is provided solely due to the provisions of § 38.2-3418 of the Code of Virginia

Va. Code Section 38.2-3418.1: Mammography

CPT Codes

76092	Screening Mammography, bilateral

Va. Code Section 38.2-3411.1: Child Health Supervision, Services (Well Baby Care)

CPT Codes

90700	Immunization, active; diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP)
90701	Diphtheria and tetanus toxoids and pertussis vaccine (DTP)
90702	Diphtheria and tetanus toxoids (DT)
90703	Tetanus toxoid
90704	Mumps virus vaccine, live
90705	Measles virus vaccine, live, attenuated
90706	Rubella virus vaccine, live
90707	Measles, mumps and rubella virus vaccine, live
90708	Measles, and rubella virus vaccine, live
90709	Rubella and mumps virus vaccine, live
90710	Measles, mumps, rubella, and varicella vaccine
90711	Diphtheria, tetanus, and pertussis (DTP) and injectable poliomyelitis vaccine
90712	Polio virus vaccine, live, oral (any type (s))

90716	Varicella (chicken pox) vaccine
90720	Diphtheria, tetanus, and pertussis (DTP) and Hemophilus influenza B (HIB) vaccine
90737	Hemophilus influenza B

New Patient

99381	Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures, new patient; infant (age under 1 year)
99382	early childhood (age 1 through 4 years) (99381)
99383	late childhood (age 5 through 11 years) (99381)

Established Patient

99391	Periodic reevaluation and management of a healthy individual requiring a comprehensive history, comprehensive examination, the identification of risk factors and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under 1 year)
99392	early childhood (age 1 through 4 years) (99391)
99393	late childhood (age 5 through 11 years) (99391)
99178	Administration and medical interpretation of developmental tests
81000	Urinalysis
84030	Phenylalanine (PKU), blood
86580	Tuberculosis-intradermal
86585	Tuberculosis, tine test

B. Uniform Billing Code Numbers (UB-82)

PLACE OF SERVICE CODES

Field Values		Report As:
10	Hospital, inpatient	Inpatient
1S	Hospital, affiliated hospice	Inpatient
1Z	Rehabilitation hospital, inpatient	Inpatient
20	Hospital, outpatient	Outpatient
2F	Hospital-based ambulatory surgical facility	Outpatient
2S	Hospital, outpatient hospice services	Outpatient
2Z	Rehabilitation hospital, outpatient	Outpatient
30	Provider's office	Outpatient
3S	Hospital, office	Outpatient
40	Patient's home	Outpatient
4S	Hospice (Home hospice services)	Outpatient
51	Psychiatric facility, inpatient	Inpatient
52	Psychiatric facility, outpatient	Outpatient
53	Psychiatric day-care facility	Partial Hospitalization
54	Psychiatric night-care facility	Partial Hospitalization
55	Residential substance abuse treatment facility	Inpatient
56	Outpatient substance abuse treatment facility	Outpatient
60	Independent clinical laboratory	Outpatient
70	Nursing home	Inpatient
80	Skilled nursing facility/extended care facility	Inpatient
90	Ambulance; ground	Outpatient
9A	Ambulance; air	Outpatient
9C	Ambulance; sea	Outpatient
00	Other unlisted licensed facility	Outpatient

Important Notice

Attached is a copy of Insurance Regulation 38 Rules Governing the Reporting of Cost and Utilization Data Relating to Mandated Benefits and Mandated Providers. This copy is being provided to you as a replacement for the copy sent to your company on November 28, 1994, (which has the order of the Commission dated November 22, 1994, attached), and is the official version of the final regulation.

While the substance of the regulation has not changed, sections have been renumbered in this final version, due to the requirements for publication in the Virginia Register of Publications. As a result, the sections referenced on page one of the Form MB-1 differ. This has no impact upon the completion of Form MB-1, but companies need to be sure that the instructions used when completing Form MB-1 are consistent with the final version of the regulation.

It is suggested that companies use a diskette when reporting data to the Bureau of Insurance. If companies submit typed Form MB-1's, it is recommended that the Form MB-1 and instructions attached to Administrative Letter 1993-5 be used. These instructions should also be used when companies submit completed form MB1s on diskette.

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

REVISED

INSURANCE REGULATION NO. 38

RULES GOVERNING THE REPORTING OF COST AND UTILIZATION DATA RELATING TO MANDATED BENEFITS AND MANDATED PROVIDERS

Effective Date: ~~October 1, 1991~~
December 1, 1994

RULES GOVERNING THE REPORTING OF COST AND UTILIZATION DATA RELATED TO MANDATED BENEFITS AND MANDATED PROVIDERS

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RULES GOVERNING THE REPORTING OF COST AND UTILIZATION DATA RELATING TO MANDATED BENEFITS AND MANDATED PROVIDERS

~~§ 1. Authority.~~

~~This Regulation is issued pursuant to the authority vested in the Commission under §§ 38.2-223 and 38.2-3419.1 of the Code of Virginia.~~

~~§ 2.~~ §1. Purpose.

The purpose of this regulation is to implement § 38.2-3419.1 of the Code of Virginia with respect to mandated health insurance benefits and providers:

This regulation is designed to:

~~(a)~~ 1. Provide the format for the reporting of costs and utilization associated with mandated benefits and providers;

~~(b)~~ 2. Describe the system for reporting such data;

~~(c)~~ 3. Define the information that is required to be reported; and

~~(d)~~ 4. Report general data related to costs and utilization associated with mandated benefits and mandated providers. However, due to the numerous means of filing claims through various procedure codes, the regulation limits the data requested to that information required to be submitted.

~~§ 3. Effective Date.~~

~~This Regulation shall be effective on October 1, 1991.~~

~~§ 4.~~ § 2 Scope.

~~A.~~ This regulation shall apply to every insurer, health services plan and health maintenance organization ~~issuing~~ licensed to issue policies of accident and sickness insurance ~~or~~ , subscription contracts , or evidences of coverage in this Commonwealth ~~unless exempted by subsection B of this section~~.

~~B. This regulation does not apply to:~~

~~1. Insurers with Virginia annual written premiums for accident and sickness policies or subscription contracts of less than $500,000; or~~

~~2. Cooperative nonprofit life benefit companies and mutual assessment life, accident and sickness insurers; or~~

~~3. Insurers that solely issue policies not subject to the mandated benefits or mandated provider requirements of §§38.2-3408 through 38.2-3419 and 38.2-4221 of the Code of Virginia.~~

~~§ 5.~~ § 3. Definitions.

For the purposes of this regulation:

"Applicable policy" or "contract" means any accident and sickness insurance policy providing hospital, medical and surgical or major medical coverage on an expense incurred basis or any accident and sickness subscription contract or any health care plan provided by a health maintenance organization issued or issued for delivery in the Commonwealth of Virginia.

~~A.~~ "Earned premiums" means the aggregate of the earned premium on all policies during a given period. The figure is calculated by adding the premiums written to the unearned premiums as of the beginning of the period and subtracting the unearned premiums as of the end of the period.

~~B.~~ "Incurred claims" means the total losses sustained whether paid or unpaid.

"Insurer" means any association, aggregate of individuals, business, corporation, individual, joint-stock company, Lloyds type of organization, organization, partnership, receiver, reciprocal or interinsurance exchange, trustee or society engaged in the business of making contracts of insurance, as set forth in § 38.2-100 of the Code of Virginia.

~~C.~~ "Mandated benefits" means those benefits that must be included or offered in policies delivered or issued for delivery in the Commonwealth as required by §§ [~~38.2-3408~~ 38.2-3409] through 38.2-3419 of the Code of Virginia.

~~D.~~ "Mandated providers" means those practitioners that are listed in §§ 38.2-3408 and 38.2-4221 of the Code of Virginia.

~~E.~~ "Paid claims" means the aggregate of loss payments, less deductions for all credits, except that no deduction is made for reinsurance recoveries, during a given period.

"Reporting period" means the calendar year immediately preceding the May 1 reporting date.

~~F.~~ "Written premiums" means gross premiums written minus premiums on policies cancelled and all returned premiums during a given period. Premiums paid to reinsurance carriers on reinsurance ceded are not deducted.

§ 4. Reporting requirements.

A. Full report required. Except as set forth in subsections B and C of this section, all insurers, health services plans and health maintenance organizations licensed to issue policies of accident and sickness insurance or subscription contracts in the Commonwealth of Virginia must file a full and complete Form MB-1 report in accordance with the provisions of § 5 of these rules.

B. Exemption: No report required. Any insurer, health services plan or health maintenance organization whose total Virginia annual written premiums for all accident and sickness policies or subscription contracts, as reported to the Commission on its Annual Statement for a particular reporting period is less than $500,000 shall, for that reporting period, be

exempt from filing a report as required by these rules, and shall not be required to notify the Commission of such exemption other than through the timely filing of its Annual Statement.

C. Eligibility to file abreviated report. Any insurer, health services plan or health maintenance organization that does not qualify for an exemption under subsection B of this section may file an abbreviated report, as described in subsection D of this section if its Virginia annual written premiums for applicable policies or contracts, as defined in § 3 of these rules, that were subject to the requirements of § 38.2-3408 or § 38.2-4221, and the requirements of §§ 38.2-3409 through 38.2-3419 of the Code of Virginia during the reporting period total less than $500,000.

D. Abbreviated report defined. The abbreviated report shall include a completed first page of the Form MB-1 report format prescribed by the Commission in Appendix A of these rules, or as later modified pursuant to § 6 of these rules, along with a breakdown of the insurer's, health services plan's, or health maintenance organization's Virginia written premiums for all accident and sickness policies or contracts for the reporting period by policy type (e.g., Medicare supplement, major medical, disability income, limited benefit) and by situs (e.g., Virginia, Illinois).

~~§6.~~ § 5. Procedures.

A. Each insurer, health services plan or health maintenance organization shall submit a full and complete Form MB-1 report ~~for the preceding calendar year's claims on mandated benefits and mandated providers~~ to the Bureau of Insurance by May 1, of each year ~~beginning in 1992~~ unless ~~exempted from this requirement by the provisions of subsection 4B of this Regulation.~~:

1. It is exempted from this requirement by § 4 B of these rules; or
2. It is eligible to file an abbreviated report pursuant to § 4 C of these rules. Abbreviated reports must be submitted by May 1 of each year.

B. The Form MB-1 report shall be filed in the format prescribed in ~~the Appendices to this Regulation~~ Appendix A of these rules. ~~The experience of group and non-group business shall be reported separately.~~ Information shall be converted to the required coding systems by the insurer, health services plan or health maintenance organization prior to submission to the Bureau of Insurance.

C. Reports may be filed by use of machine readable computer diskettes issued by the Bureau of Insurance expressly for this purpose, although typewritten reports are acceptable provided that the exact format set forth in these rules, and as subsequently modified as set forth in § 6 of these rules, is utilized.

§ 6. Annual notification and modification of reporting form.

The Bureau of Insurance shall be permitted to modify the data requirements of the MB-1 reporting form and data reporting instructions on an annual basis. Any such modifications, including but not limited to the addition of new benefit or provider categories as necessitated by the addition of new mandated benefit or provider requirements to the Code of Virginia, shall be provided to all entities described in § 2 of these rules, in the form of an administrative letter sent by regular mail to the entity's mailing address shown in the Bureau's records. Failure by an entity to receive such annual notice shall not be cause for exemption or grounds for noncompliance with the reporting requirements set forth in these rules.

§ 7. Penalties.

The failure by an insurer, health services plan or health maintenance organization, unless exempt pursuant to [~~§ 4 B~~ § 2 B] of these rules, to file a substantially complete and accurate report ~~on cost and utilization data relating to mandated benefits and mandated providers~~ as required by these rules by the required ~~day~~ date may be considered a willful violation and is

subject to an appropriate penalty in accordance with §§ 38.2-218 and 38.2-219 of the Code of Virginia.

§ 8. Severability.

If any provision of ~~this Regulation~~ these rules or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of ~~this Regulation~~ these rules and the application of such provision to other persons or circumstances shall not be affected thereby.

Appendix A. Data Reporting Instructions and Form MB-1

~~A. Format and Timing of Reports.~~

~~1. Cost and utilization data relating to mandated benefits and mandated providers must be submitted in the format prescribed in Appendix B of this Regulation and must be submitted no later than May 1 of each year beginning in 1992. A separate report is required for each insurer.~~

~~2. It is preferred that reports be filed by the use of machine readable computer diskettes, although written reports are acceptable provided that the exact format set forth in this regulation is utilized. The Automated Systems Section of the State Corporation Commission's Bureau of Insurance should be contacted at (804) 371-0394 for details regarding the computerized transmission of reports.~~

~~3. Insurers writing less than $500,000 of accident and sickness premiums in a given year in the Commonwealth of Virginia are exempt from the reporting requirements for that year according to § 4 of this Regulation. Each insurer claiming an exemption for a given calendar year is responsible for notifying the Bureau of Insurance by completing and filing Page 1 of Form MB-1 prior to May 1, of the following year in lieu of a full report.~~

~~B.~~A. Specifications for Cost and Utilization Data

1. Parts A and B of [~~form~~ Form] MB-1 require specific claims and other actuarial data for individual ~~business on Benefit Worksheet #1 and Provider Worksheet #1~~ and ~~for~~ group business ~~on Benefit Worksheet #2 and Provider Worksheet #2~~. In determining the cost of each mandate, it is expected that actual claims ~~or actuarial~~ data will be used. ~~Use~~ Claims for the CPT-4 or ICD-9CM Codes listed under each mandate in Appendix ~~C~~B of ~~this Regulation~~ these rules are to be used to determine claim costs. In addition, §§ 38.2-3408 through 38.2-3419 and 38.2-4221 of the Code of Virginia must be consulted for complete definitions of the required benefits and providers.

2. Part C of [~~form~~ Form] MB-1 requires that a standard policy be defined and the annual premium disclosed. The portions of that premium attributable to Virginia's mandated benefits and providers are to be outlined with respect to single and family coverage within both the individual and group categories of business. Additional ~~questions are also asked~~ information is also required.

3. Part D of [~~form~~ Form] MB-1 requires that utilization and claims data be disclosed for various providers and procedures.

4. The Physician's Current Procedural Terminology, Fourth Edition (CPT-4) and the Internal Classification of Disease 9th Revision Clinical Modification Third Edition (ICD-9CM) should be used as the basis for defining the information to be reported. Companies using a system other than CPT-4 or ICD-9CM should report the required data under a

comparable system in use by that company that has been converted to CPT-4 or ICD-9CM.

5. Provider information should be reported by category of provider as they are listed. ~~We are requesting~~ Information is required only for the providers mandated by §§ 38.2-3408 and 38.2-4221 and the physician counterpart for that provider. Place of service can be identified by Uniform Billing Code Numbers (UB-82). A partial listing of UB-82 codes is included in Appendix ~~C~~B of ~~this Regulation~~ these rules.

6. For data regarding group coverage, include only ~~benefits~~ claims paid or incurred for master contracts delivered or issued for delivery to group policyholders located in Virginia.

~~7. Report claim amounts separately for group and individual contracts.~~

~~8. For newborn children coverage data, include claims for newborns less than 32 days old.~~

~~9. For dependent children coverage, include all health care claims for dependents beyond the age for cut-off for coverage of dependents that is specified in your contracts in the absence of a physical handicap/mental retardation (identified in this manner will be those claims for dependents other than those routinely covered).~~

~~10.~~7. Claims may be reported on an "incurred claims" or "paid claims" basis. ~~Indicate if not on a "paid claims" basis.~~ The same basis must be used throughout the report.

~~11~~8. All costs of health care provided because of a mandated benefit or mandated provider should be attributed to that mandate for Parts A, B and C.

~~Appendix [B.]~~ Form MB-1

Form MB-1

Annual Report of Cost and Utilization Data
Relating to Mandated Benefits and Mandated Providers
Pursuant to § 38.2-3419.1 of the Code of Virginia

Reporting ~~Year~~ Period _____

Company Name _____

Group Name _____

Mailing Address _____

_____

NAIC#_____ Group NAIC #_____

Name of Person Completing Report _____

Title_____

Direct Telephone #_____

Mailing Address_____

_____

Total accident and sickness premiums written in Virginia for all accident and sickness lines including credit, disability income, and all others, whether subject to §§ 38.2-3408 or 38.2-4221 and §§ 38.2-3409 through 38.2-3419 of the Code of Virginia or not, as reported on the Company's Annual Statement for the reporting period: $_____

Total accident and sickness premiums written in Virginia on applicable policies and contracts, as defined in [~~§ 3 A~~ § 3] of these rules that are subject to §§ 38.2-3408 or 38.2-4221 and §§ 38.2-3409 through 38.2-3419 for the reporting period: $_____

~~in the year _____ the amount of $_____~~

~~Is the reporting company a cooperative nonprofit life benefit company or mutual assessment life, accident and sickness insurer?~~

~~[ ] Yes [ ] No~~

~~Does this company solely issue policies not subject to the mandated benefits and mandated provider requirements of §§ 38.2-3408 through 38.2-3419 and 38.2-4221 of the Code of Virginia?~~

~~[ ] Yes [ ] No~~

Does this company claim ~~an exemption~~ eligibility to file an abbreviated report under ~~Section 4~~ [~~§5 C~~ § 4 C] of Regulation No. 38 for this reporting ~~year~~ period?

[ ] Yes, and filing ~~only this page~~ the abbreviated report allowed for in [~~§ 5 C.~~ § 4 C.]

[ ] No, and filing a complete report.

~~Signature~~ _____ ~~Date~~ _____

Part A: ~~Benefit Worksheet # 1 - Individual~~ Claim Information - Benefits*

Enter the basis on which claim data presented throughout this report was collected (either "paid" or "incurred"): [ ]

~~* Benefit~~ INDIVIDUAL		a	b	c	d	e	f	g
Va. Code Section	Description	Number of Visits	Number of Days	Total Claims Payments	Number of Contracts	Claim Cost Per Contract	Annual Administrative Cost	Percent of Total Health Claims ~~Paid~~
38.2-3409	Dependent Children ~~Coverage~~ (Handicapped)							
38.2-3410	Doctor to Include Dentist							
38.2-3411	Newborn Children							
38.2-3412.1	~~Inpatient~~ Mental / Emotional / Nervous							
	Inpatient							
	Partial Hospital.							
38.2-3412.1	Alcohol and Drug Dependence							
	Inpatient							
	Partial Hospital.							
	~~Obstetrical Services~~							
38.2-3418	Pregnancy from Rape / Incest							
38.2-3418.1	Mammography							
38.2-3411.1	Child Health Supervision							

Enter total claims paid or incurred on individual policies subject to the above requirements (this figure should be used in calculating the figures required for column g): [ ]

* include information and amounts paid or incurred on hospital bills and other providers

a: number of provider and physician visits

b: number of inpatient or partial hospital days ~~in facility~~ (if applicable)

c: total of claims paid or incurred for this mandate

d: number of contracts in force in Virginia containing the required or optional coverage

e: claim cost per contract = column c divided by column d

f: the administrative cost of complying with this mandate during the reporting ~~year~~ period

g: claims paid or incurred for this benefit as a percentage of the total amount of health claims paid or incurred on individual policies or contracts subject to this reporting requirement ~~for Virginia policyholders by this company~~

~~Benefit Worksheet # 2 - Group~~

~~* Benefit~~ GROUP Va. Code Section	Description	a Number of Visits	b Number of Days	c Total Claims Payments	d Number of ~~Contracts~~ Certificates	e Claim Cost Per ~~Contract~~ Certificate	f Annual Administrative Cost	g Percent of Total Health Claims ~~Paid~~
38.2-3409	Dependent Children ~~Coverage~~ (Handicapped)							
38.2-3410	Doctor to Include Dentist							
38.2-3411	Newborn Children							
38.2-3412.1	Mental / Emotional / Nervous:							
	Inpatient							
	Partial Hospital.							
	Outpatient							
38.2-3412.1	Alcohol and Drug Dependence							
	Inpatient							
	Partial Hospital.							
	Outpatient							
38.2-3414	Obstetrical Services							
	Normal Pregnancy							
	All Other							
38.2-3418	Pregnancy from Rape / Incest							
38.2-3418.1	Mammography							
38.2-3411.1	Child Health Supervision							

Enter total claims paid or incurred on group policies that are subject to the above requirements (this figure should be used in calculating the figures required for column g): [ ]

* include information and amounts paid or incurred on hospital bills and other providers ~~{~~for all health care expenses incurred because of this mandate~~}~~

a: number of provider and physician visits

b: number of inpatient or partial hospital days ~~in facility~~ (if applicable)

c: total of claims paid or incurred for this mandate

d: number of certificates ~~in Virginia {with this coverage}~~ containing the required or optional coverage

e: claim cost per ~~contract~~ certificate = column c divided by column d

f: the administrative cost of complying with this mandate during the reporting ~~year~~ period

g: claims paid or incurred for this benefit as a percentage of the total amount of ~~{all}~~ health claims paid or incurred on group policies or contracts subject to this reporting requirement ~~for Virginia policyholders by this company~~

Part B: ~~Provider Worksheet # 1 – Individual~~ Claim Information - Providers

~~Provider~~ INDIVIDUAL

Va. Code Sections 38.2-3408 & 38.2-4221	a Number of Visits	b Total Claims Payments	c Cost Per Visit	d Number of Contracts	e Claim Cost Per Contract	f Annual Administrative Cost	g Percent of Total Health Claims ~~Paid~~
Chiropractor							
Optometrist							
Optician							
Psychologist							
Clinical Social Worker							
Podiatrist							
Professional Counselor							
Physical Therapist							
Clinical Nurse Specialist*							
Audiologist							
Speech Pathologist							

* rendering mental health services

a: number of visits to this provider group for which claims were paid or incurred in Virginia
b: total dollar amount of claims paid to this provider group in Virginia
c: cost per visit = column b divided by column a
d: number of individual contracts ~~in force in Virginia~~ subject to this reporting requirement
e: claim cost per contract = column b divided by column d
f: the ~~annual~~ administrative cost ~~associated with compliance~~ of complying with this mandate during the reporting period
g: claims paid or incurred for services administered by ~~this~~ each provider ~~group~~ type as a percentage of the total amount of health claims paid or incurred on individual policies or contracts subject to this reporting requirement ~~for Virginia policyholders by this company~~

~~Provider Worksheet # 2 - Group~~

~~Provider~~ GROUP Va. Code Sections 38.2-3408 & 38.2-4221	a Number of Visits	b Total Claims Payments	c Cost Per Visit	d Number of ~~Contracts~~ Certificates	e Claim Cost Per ~~Contracts~~ Certificate	f Annual Administrative Cost	g Percent of Total Health Claims ~~Paid~~
Chiropractor							
Optometrist							
Optician							
Psychologist							
Clinical Social Worker							
Podiatrist							
Professional Counselor							
Physical Therapist							
Clinical Nurse Specialist*							
Audiologist							
Speech Pathologist							

* rendering mental health services

a: number of visits to this provider group for which claims were paid or incurred in Virginia
b: total dollar amount of claims paid to this provider group in Virginia
c: cost per visit = column b divided by column a
d: number of certificates ~~in Virginia~~ subject to this reporting requirement
e: claim cost per ~~contract~~ certificate = column b divided by column d
f: the ~~annual~~ administrative cost ~~associated with compliance~~ of complying with this mandate during the reporting period
g: claims paid or incurred for services administered by ~~this~~ each provider ~~group~~ type as a percentage of the total amount of health claims paid or incurred on group contracts subject to this reporting requirement ~~for Virginia policyholders by this company~~

Part C: Premium Information

1. Please use what you consider to be your standard policy to answer this question. For the individual policy used as your base calculations in the question below:

- What is the deductible? _____
- What is the coinsurance? _____
- What is the individual/employee out-of-pocket maximum? _____

For the group policy used as your base calculation in the question below:

- What is the deductible? _____
- What is the coinsurance? _____
- What is the individual/employee out-of-pocket maximum? _____

For your standard health insurance policy in Virginia, ~~what is~~ provide the total annual premium ~~including mandates, and what amount is added to~~ that would be charged per unit of coverage assuming inclusion of all of the benefits and providers listed below. In addition, provide the portion (dollar amount) of the annual premium ~~of~~ for each ~~type~~ policy ~~for~~ that is attributable to each mandate listed~~?~~. If the company does not have a "Family" rating category, coverage for two adults and two children is to be used when calculating the required family premium figures.

Please indicate where coverage under your policy exceeds Virginia's mandates.

	Va. Code Section	Individual Policy Single	Individual Policy Family	Group Certificates Single	Group Certificates Family
~~Total~~ Annual ~~Policy~~ Premium for Standard Policy Described Above		_____	_____	_____	_____
Premium ~~for~~ Attributable to Each Mandate:					
Dependent Children ~~Coverage~~ (Handicapped)	38.2-3409		_____		_____
Doctor to Include Dentist	38.2-3410	_____	_____	_____	_____
Newborn Children	38.2-3411	_____	_____	_____	_____
Mental/Emotional/Nervous (Mental Disabilities)	38.2-3412.1	_____	_____	_____	_____
Inpatient		_____	_____	_____	_____
Partial Hospitalization		_____	_____	_____	_____
* Outpatient				_____	_____
*Alcohol and Drug Dependence	38.2-3412.1			_____	_____

Inpatient					
Partial Hospitalization					
Outpatient					
*Obstetrical Services	38.2-3414				
Normal Pregnancy					
All Other					
Pregnancy from Rape or Incest	38.2-3418				
*Mammography	38.2-3418.1				
*Child Health Supervision	38.2-3411.1				

* Denotes mandated offer

Chiropractor	38.2-3408/38.2-4221				
Optometrist	38.2-3408/38.2-4221				
Optician	38.2-3408/38.2-4221				
Psychologist	38.2-3408/38.2-4221				
Clinical Social Worker	38.2-3408/38.2-4221				
Podiatrist	38.2-3408/38.2-4221				
Professional Counselor	38.2-3408/38.2-4221				
Physical Therapist	38.2-3408/38.2-4221				
Clinical Nurse Specialist**	38.2-3408/38.2-4221				
Audiologist	38.2-3408/38.2-4221				
Speech Pathologist	38.2-3408/38.2-4221				

** rendering mental health services

2. What is the number of individual policies and/or group certificates issued or renewed by ~~your~~ the Company ~~in 1991~~ in Virginia during the reporting period?

	Single	Family
Individual	_____	_____
Group	_____	_____

3. What is the number of individual policies and/or group certificates in force for your company in Virginia as of ~~December 31, 1991 in Virginia~~ the last day of the reporting period?

	Single	Family
Individual	_____	_____
Group	_____	_____

4. What would be the annual premium for an individual policy with no mandated benefits or mandated providers for a 30 year old male in the Richmond area in your standard premium class? What would be the cost for a policy for the same individual with present mandates? (Assume coverage including $250 deductible, $1,000 stop-loss limit, 80% co-insurance factor, $250,000 policy maximum.) If you do not issue a policy of this type, please provide the premium for a 30 year old male in your standard premium class for the policy that you offer that is most similar to the one described and summarize the differences from the described policy.

Without Mandates $_____

With Mandates $_____

Differences in Policy _____
_____
_____
_____

5. ~~Do you add an amount to the annual premium of a group certificate to cover the cost of conversion to an individual policy? Yes_____ No_____~~

~~If yes, what is the average dollar amount:~~
~~Single_____ Family_____~~

~~If no, is that cost covered in the annual premium of the individual policy? Yes_____ No_____~~

The following questions concern the cost of converting group coverage to an individual policy. Answer only those questions which are relevant to your company's practices.

a. If the company adds an amount to the annual premium of a group policy or certificate to cover the cost of conversion to an individual policy, provide the average dollar amount per certificate:

_____ Single: _____ Family: _____

b. If the cost of conversion is instead covered in the annual premium of the individual policy, provide the average dollar amount attributable to the conversion requirement:

_____ Single: _____ Family: _____

c. If the cost of conversion is instead covered by a one-time charge made to the group policyholder for each conversion, provide the average dollar amount:

_____ Single: _____ Family: _____

Part D: Utilization and Expenditures for Selected Procedures by Provider Type

~~Select~~ Selected Procedure Codes are listed here to obtain information about utilization and costs for specific types of services. Please identify expenditures and ~~only~~ visits for the Procedure Codes indicated. Other claims should not be included here. Individual and group data must be combined for this part of the report.

1. Procedure Code ~~9001~~99203
   Office Visit, Intermediate Service to New Patient

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Clinical Social Worker			
Physical Therapist			
Podiatrist			
Professional Counselor			
Psychologist			
Physician			

2. Procedure Code 90844
   Medical Psychotherapy, 45 to 50 Minute Session

	Number of Visits	Claims Payments	Cost Per Visit
Clinical Nurse Specialist*			
Clinical Social Worker			
Professional Counselor			
Psychiatrist			
Psychologist			
Physician			

3. Procedure Code 90853
   Group Medical Psychotherapy

	Number of Visits	Claims Payments	Cost Per Visit
Clinical Nurse Specialist*			
Clinical Social Worker			
Professional Counselor			
Psychiatrist			
Psychologist			
Physician			

* rendering mental health services

4. Procedure Code 92507
Speech, Language or Hearing Therapy; Individual

	Number of Visits	Claims Payments	Cost Per Visit
Audiologist			
Clinical Social Worker			
Physical Therapist			
Professional Counselor			
Speech Pathologist			
Physician			

5. Procedure Code 97110
Physical Medicine Treatment, 30 Minutes, Therapeutic Exercise

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			
Speech Pathologist			

6. Procedure Code 97124
Physical Medicine Treatment, Massage

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			

7. Procedure Code 97128
Physical Medicine Treatment, Ultrasound

	Number of Visits	Claims Payments	Cost Per Visit
Chiropractor			
Physical Therapist			
Physician			
Podiatrist			

8. Procedure Code 92352
Fitting of Spectacle Prosthesis for Aphakia, monofocal

	Number of Visits	Claims Payments	Cost Per Visit
Ophthalmologist			
Optician			
Optometrist			
Physician			

9. Procedure Code ~~1176~~11750
Excision of ~~Ingrown Toenail~~ Nail and Nail Matrix, Partial or Complete, for Permanent Removal

	Number of Visits	Claims Payments	Cost Per Visit
Physician			
Podiatrist			

Appendix ~~C.~~ B. CPT-4, ICD-9CM, and UB-82 References.

A. CPT and ICD-9CM Codes

Va. Code Section 38.2-3410: Doctor to Include Dentist
(Medical services legally rendered by dentists and covered under contracts other than dental)

ICD Codes

520-529	Diseases of oral cavity, salivary glands and jaws
~~524~~	~~Dentofacial anomalies, including malocclusion~~
~~525~~	~~Other diseases and conditions of the teeth and supporting structure~~
~~526~~	~~Diseases of the jaws~~

Va. Code Section 38.2-3411: Newborn Children
(children less than 32 days old)

ICD Codes

~~740-759.9~~ 740-759	Congenital anomalies
760-763	~~Certain conditions originating in the perinatal period~~ Maternal causes of perinatal morbidity and mortality
764-779	Other conditions originating in the perinatal period

CPT Codes

99295	Initial NICU care, per day, for the evaluation and management of a critically ill neonate or infant
99296	Subsequent NICU care, per day, for the evaluation and management of a critically ill and unstable neonate or infant
99297	Subsequent NICU care, per day, for the evaluation and management of a critically ill and stable neonate or infant
~~9022~~99431	History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records

99432 Normal newborn care in other than hospital or birthing room setting including physical examination of baby and conference(s) with parent(s)

~~9028~~99433 ~~Normal Newborn Services~~ Subsequent hospital care for the evaluation and management of a normal newborn, per day

99440 Newborn resuscitation: care of the high risk newborn at delivery, including, for example, inhalation therapy, aspiration, administration of medication for initial stabilization

Va. Code Section 38.2-3412.1: Mental/Emotional/Nervous Disorders
(must use UB-82 place-of-service codes from Section B of this Appendix to differentiate between inpatient, partial hospitalization, and outpatient claims where necessary)

ICD Codes

290, 293-294 Organic Psychotic Conditions

295-299 Other psychoses

300-302, 306-316 Neurotic disorders, personality disorders, other non-psychotic mental disorders

317-319 Mental retardation

CPT Codes ~~Distinguish between inpatient and outpatient~~

~~90825 Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes~~

~~90801 Psychiatric diagnostic interview examination, including history, mental status, or disposition~~

99221-99223 Initial hospital care, per day, for the evaluation and management of a patient

99231-99233 Subsequent hospital care, per day, for the evaluation and management of a patient

99238 Hospital discharge day management

~~90600-90643~~ 99241-99263 Consultation for psychiatric evaluation of a patient includes examination of a patient and exchange of information with primary physician and other informants such as nurses or family members, and preparation of report[.]

90801 Psychiatric diagnostic interview examination, including history, mental status, or disposition

90820 Interactive medical psychiatric diagnostic interview examination

90825 Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes

90830 Psychological testing by physician, with written report per hour

90835 Narcosynthesis for psychiatric diagnostic and therapeutic purposes

90841 Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy; time unspecified

90842 approximately 75 to 80 minutes (90841)

90843 approximately 20 to 30 minutes (90841)

90844 approximately 45 to 50 minutes (90841)

90845 Medical psychoanalysis

90846 Family medical psychotherapy (without the patient present)

90847 Family medical psychotherapy (conjoint psychotherapy) by a physician, with continuing medical diagnostic evaluation, and drug management when indicated

90849 Multiple family group medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated

90853 Group medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated

90855 Interactive individual medical psychotherapy

90857 Interactive group medical psychotherapy

90862 Pharmacologic management, including prescription use, and review of medication with no more than minimal medical psychotherapy

90870	Electro convulsive therapy, single seizure
90871	Multiple seizures, per day
	Other Psychiatric Therapy
90880	Medical hypnotherapy
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them to assist patient
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers
	Other Procedures
90899	Unlisted psychiatric service/procedure

Va. Code Section 38.2-3412.1: Alcohol and Drug Dependence

ICD Codes

~~291-291.9~~291	Alcohol Psychoses
303	Alcohol dependence syndrome

~~ICD Codes~~

~~292-292.9~~292	Drug Psychoses
304	Drug dependence
~~305-305.9~~305	Nondependent abuse of drugs

CPT Codes

Same as listed above for Mental/Emotional/Nervous Disorders, but for above listed conditions.

Va. Code Section 38.2-3414: Obstetrical Services

Normal Pregnancy

ICD Codes

650	Normal delivery without abnormality or complication classifiable elsewhere in categories 630-676, and with spontaneous cephalic delivery, without mention of fetal manipulation or instrumentation

CPT Codes

Any codes in the maternity care and delivery range of 59000-59899 associated with ICD Code 650 listed above

All Other Obstetrical Services

ICD Codes

630-648, 651-676	Complications of pregnancy, childbirth, and puerperium

CPT Codes

Incision, Excision, Introduction, and Repair

59000	Amniocentesis, any method
59012	Cordocentesis (intrauterine), any method
59015	Chorionic villus sampling, any method
59020	Fetal contraction stress test
59025	Fetal scalp blood sampling
59050	Initiation and/or supervision of internal monitoring during labor by consultant with report (separate procedure)
59100	Hysterotomy, abdominal (e.g., for hydatidiform mole, abortion)
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach
59121	tubal or ovarian, without salpingectomy and/or oophorectomy (59120)

59130 abdominal pregnancy (59120)

59135 interstitial, uterine pregnancy requiring total hysterectomy (59120)

59136 interstitial, uterine pregnancy with partial resection of uterus (59120)

59140 cervical, with evacuation (59120)

59150 Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy

59151 with salpingectomy and/or oophorectomy (59150)

59160 Curettage, postpartum (separate procedure)

59200 Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)

59300 Episiotomy or vaginal repair, by other than attending physician

59320 Cerclage or cervix, during pregnancy; vaginal

59325 abdominal (59320)

59350 Hysterorrhaphy of ruptured uterus

Delivery, Antepartum and Postpartum Care

~~CPT Codes~~

59400 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care

59409 Vaginal delivery only (with or without episiotomy and/or forceps)

~~59410~~59410 ~~Vaginal delivery only (with or without epistiotomy and/or forceps)~~ including postpartum care (59409)

~~59412~~59412 External cephalic version, with or without tocolysis ~~(list in addition to code(s) for delivery)~~

~~59414~~59414 Delivery of placenta following delivery of infant outside of hospital

~~59420~~ ~~Antepartum care only (separate procedure)~~

59425 Antepartum care only; 4-6 visits

59426 7 or more visits (59425)

~~5493~~59430 Postpartum care only (separate procedure)

Cesarean Delivery

59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care

59514 Cesarean delivery only

59515 ~~Cesarean delivery only~~ including postpartum care (59514)

59525 Subtotal or total hysterectomy after cesarean delivery (list in addition to 59510 or 59515)

Abortion

~~90000-90280-~~99201-99233 Medical treatment of spontaneous complete abortion, any trimester

59812 Treatment of ~~spontaneous~~ incomplete abortion, any trimester, completed surgically

~~5892~~59820 Treatment of missed abortion, completed surgically, first trimester

~~59821~~59821 second trimester (59820)

~~5893~~59830 Treatment of septic abortion, completed surgically

59840 Induced abortion, by dilation and curettage

59841 Induced abortion, by dilation and evacuation

59850 Induced abortion, by one or more intra-amniotic injections (amniocentesis-injections), including hospital admission and visits, delivery of fetus and secundines [~~)~~];

59851 with dilation and curettage and/or evacuation (59850)

59852 with hysterotomy (failed intra-amniotic injection) (59850)

Other Procedures

59870 Uterine evacuation and curettage for hydatidiform mole

~~5899959899~~ Unlisted procedure, maternity care and delivery

Anesthesia

00850 Cesarean

00855 Cesarean hysterectomy

00857 Continuous epidural analgesia for labor and cesarean section

Va. Code Section 38.2-3418: Pregnancy from Rape/Incest

Same Codes as Obstetrical Services/Any Other Appropriate in cases where coverage is provided solely due to the provisions of § 38.2-3418 of the Code of Virginia

Va. Code Section 38.2-3418.1: Mammography

CPT Codes

76092 Screening Mammography, bilateral

Va. Code Section 38.2-3411.1: Child Health Supervision, Services (Well Baby Care)

CPT Codes

90700 Immunization, active; diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP)

90701 ~~Immunization, active;~~ Diphtheria and tetanus toxoids and pertussis vaccine (DTP)

90702 Diphtheria and tetanus toxoids (DT)

90703 Tetanus toxoid

90704 Mumps virus vaccine, live

90705 Measles virus vaccine, live, attenuated

90706	Rubella virus vaccine, live
90707	Measles, mumps and rubella virus vaccine, live
90708	Measles, and rubella virus vaccine, live
90709	Rubella and mumps virus vaccine, live
90710	Measles, mumps, rubella, and varicella vaccine
90711	Diphtheria, tetanus, and pertussis (DTP) and injectable poliomyelitis vaccine
90712	Polio virus vaccine, live, oral (any type (s))
90716	Varicella (chicken pox) vaccine
90720	Diphtheria, tetanus, and pertussis (DTP) and Hemophilus influenza B (HIB) vaccine
90737	Hemophilus influenza B

New Patient

~~90755~~	~~Infant care to one year of age, with a maximum of 12 office visits during regular office hours, including tuberculin skin testing and immunization of DPT and Oral polio~~
99381	Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures, new patient; infant (age under 1 year)
99382	early childhood (age 1 through 4 years) (99381)
99383	late childhood (age 5 through 11 years) (99381)

Established Patient

	~~Interval history and exam related to the healthy individual, including anticipatory guidance, periodic type exam~~
~~90762~~	~~Late childhood (Age 5-6 years)~~
~~90763~~	~~Early childhood (Age 1 through 4 years)~~

~~90764~~	~~Infant (Age under 1 year)~~
99391	Periodic reevaluation and management of a healthy individual requiring a comprehensive history, comprehensive examination, the identification of risk factors and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under 1 year)
99392	early childhood (age 1 through 4 years) (99391)
99393	late childhood (age 5 through 11 years) (99391)
~~9077~~99178	Administration and medical interpretation of developmental tests
81000	Urinalysis
84030	Phenylalanine (PKU), blood
86580	Tuberculosis-intradermal
86585	Tuberculosis, tine test
~~90752~~	~~late childhood (age 5 through 11)~~
~~90753~~	~~early childhood (age 1 through 4)~~
~~90754~~	~~infant (age under 1 year)~~

B. Uniform Billing Code Numbers (UB-82)

PLACE OF SERVICE CODES

Field Values		Report As:
10	Hospital, inpatient	Inpatient
1S	Hospital, affiliated hospice	Inpatient
1Z	Rehabilitation hospital, inpatient	Inpatient
20	Hospital, outpatient	Outpatient
2F	Hospital-based ambulatory surgical facility	Outpatient
2S	Hospital, outpatient hospice services	Outpatient
2Z	Rehabilitation hospital, outpatient	Outpatient
30	Provider's office	Outpatient
3S	Hospital, office	Outpatient
40	Patient's home	Outpatient
4S	Hospice (Home hospice services)	Outpatient
51	Psychiatric facility, inpatient	Inpatient
52	Psychiatric facility, outpatient	Outpatient
53	Psychiatric day-care facility	~~Outpatient~~ Partial Hospitalization
54	Psychiatric night-care facility	~~Outpatient~~ Partial Hospitalization
55	Residential substance abuse treatment facility	Inpatient
56	Outpatient substance abuse treatment facility	Outpatient
60	Independent clinical laboratory	Outpatient
70	Nursing home	Inpatient
80	Skilled nursing facility/extended care facility	Inpatient
90	Ambulance; ground	Outpatient
9A	Ambulance; air	Outpatient
9C	Ambulance; sea	Outpatient
00	Other unlisted licensed facility	Outpatient