f. whether the actuary has been satisfied that all options whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

2. The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion.

D. Conformity to Standards of Practice. The memorandum shall include a statement:

> "Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum."

E. Use of Assets Supporting the Interest Maintenance Reserve and the Asset Valuation Reserve

1. An appropriate allocation of assets in the amount of the interest maintenance reserve (IMR), whether positive or negative, shall be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

2. The amount of the assets used for the AVR shall be disclosed in the table of reserves and liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets shall be disclosed in the memorandum.

F. Documentation. The appointed actuary shall retain on file, for at least seven years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:3, 22:162.1 and the Administrative Procedure Act, R.S. 49:950 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 31:2548 (October 2005).

Chapter 23. Regulation 48—Standardized Claims Forms

§2301. Purpose

A. The purpose of this regulation is to standardize the forms used in the billing and reimbursement of health care, reduce the number of forms utilized and increase efficiency in the reimbursement of health care through standardization.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2303. Definitions

CDT-1 Codes—the current dental terminology prescribed by the American Dental Association.

CPT-4 Codes—the current procedural terminology published by the American Medical Association.

HCFA—the Federal Health Care Financing Administration of the U.S. Department of Health and Human Services.

HCFA for UB92—the health insurance claim form published by HCFA for use by institutional care providers.

HCFA Form 1500—the health insurance claim form published by HCFA for use by health care providers.

HCPCS—HCFA's common procedure coding system which is based upon the AMA's *Physician Current Procedural Terminology, Fourth Edition* (CPT-4).

1. *HCPCS Level I Codes*—the AMA's CPT-4 codes with the exception of anesthesiology services.

2. *HCPCS Level 2 Codes*—the codes for physician and nonphysician services are not included in COT-4.

Health Care Provider—

1. an acupuncturist licensed under R.S. 37:1356-1360;

2. a certified registered nurse anesthetist licensed under R.S. 37:930;

3. a chiropractor licensed under R.S. 37:2801-2830.7;

4. a dentist licensed under R.S. 37:751-794;

5. a dietician and nutritionist licensed under R.S. 37:3081-3093 and 36:259U;

6. durable medical equipment suppliers;

7. an emergency medical technician licensed under R.S. 40:1231-1232;

8. a general health clinic (excluding early periodic screening diagnosis treatment clinics) certified by the Louisiana Department of Health and Hospitals;

9. a hearing aid dealer licensed under R.S. 37:2441-2465;

10. a licensed practical nurse licensed under R.S. 37:961;

11. a mental health counselor licensed under R.S. 37:1101-1115;

12. a mental health clinic licensed under R.S. 28:567;

13. a midwife licensed under R.S. 37:3240-3257;

14. an occupational therapist licensed under R.S. 37:3001-3014;

15. an optometrist licensed under R.S. 37:1052;

16. a physical therapist and physical therapist assistant licensed under R.S. 37:2401-2419;

17. a physician licensed under R.S. 37:1261-1292;

18. a physician assistant licensed under R.S. 37:1360.21-27;

19. a podiatrist licensed under R.S. 37:611-628;

20. a psychologist licensed under R.S. 37:2351-2370;

21. a registered nurse licensed under R.S. 37:911-931;

22. a rehabilitation center licensed under 42:CFR 405.1701Q;

23. a respiratory therapist licensed under R.S. 37:3351-3361;

24. a social worker licensed under R.S. 37:2701-2718;

25. a speech pathologist and audiologist licensed under R.S. 2651-2665;

26. a substance abuse counselor licensed under R.S. 37:3371-3384;

27. a substance abuse prevention/treatment program licensed under R.S. 40:1058.1-1058.3;

28. a free standing ambulatory surgical center licensed under R.S. 40:2131-2141;

29. any other health care providers as licensed by the state of Louisiana;

ICD-9-CM Codes—the disease codes in the *International Classification of Diseases, Ninth Revision,* clinical modifications published by the U.S. Department of Health and Human Services.

Institutional Care Provider—

1. an adult day health care provider licensed under R.S. 46:1971-1980;

2. an ambulatory surgical center licensed under R.S. 40:2131-2143;

3. a drug screening laboratory licensed under R.S. 49:1111-1113, 1115-1118, 1121, 1122, and 1125;

4. an end stage renal dialysis facility under 42:CFR 405.2100;

5. a home health agency licensed under R.S. 40:2009.31-2009.40;

6. a hospice licensed under R.S. 40:2181-2191;

7. a hospital licensed under R.S. 40:2100-2114;

8. a nursing home licensed under R.S. 40:2009;

9. a residential care/community group home or residential facility licensed under R.S. 46:51, 1401-1411, and 28:1-284;

10. any other institutional care provider as licensed by the state of Louisiana.

J512 Form—the uniform dental claim form approved by the American Dental Association for use by dentists.

Medicaid—Title XIX of the Federal Social Security Act.

Medicare—Title XVIll of the Federal Social Security Act.

Revenue Codes—the codes established for use by institutional care providers by the National Uniform Billing Committee.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2305. Applicability and Scope

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

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2307. Requirements for Use of HCFA Form 1500

A. Health care providers, other than dentists, shall use the HCFA Form 1500 and instructions provided by HCFA for use of the HCFA Form 1500 when billing patients or their representatives for reimbursement of claims with insurers for professional services.

B. An issuer may not require a health care provider to use any coding system for the initial filing of claims for health care services other than the following:

1. HCPCS Codes; and

2. ICD-9-CM Codes.

C. An issuer may not require a health care provider to use any other descriptor with a code or to furnish additional information with the initial submission of a HCFA Form 1500 except under the following circumstances:

1. when the procedure code used describes a treatment or service which has not been included in CPT-4 or is billed under an unlisted procedure code and a description of services is necessary; or

2. when the procedure code is followed by the CPT-4 modifier 22, 47, 50, 51, 52, 62, 66, 77, or 99; or

3. when required by a contract/agreement between the issuer and health care provider; or

4. as otherwise required by federal regulation; or

5. as otherwise required by the Office of Workers' Compensation of the Louisiana Department of Labor.

D. Use of HCFA Form 1500 shall be effective July 1, 1994 for all issuers excluding rehabilitation facilities reimbursed by Louisiana Medicaid which will have an effective date of January 1, 1995.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2309. Requirements for Use of HCFA Approved Form UB92

A. Institutional care providers shall use the HCFA approved Form UB92 and instructions provided by HCFA for use of the HCFA approved UB92 when billing patients or their representatives directly and filing claims with issuers for professional services.

B. An issuer may not require an institutional care provider to use any coding system for the initial filing of claims for health care services other than the following:

1. ICD-9-CM Codes;

2. Revenue Codes;

3. HCPCS Level I Codes;

4. HCPCS Level 2 Codes; and

5. if charges include direct service of a health care provider, the information outlined in §2307 of this regulation.

C. Use of the HCFA approved Form UB92 shall be effective July 1, 1994 for all issuers excluding nursing facilities, adult day health care facilities, and residential care facilities reimbursed by Louisiana Medicaid which shall have an effective date of January 1, 1996.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2311. Requirements for Use of J512 Form

A. A dentist shall use the J512 Form and instructions provided by the American Dental Association CDT-1 for use of the J512 Form by billing patients or their representatives directly and filing claims with issuers for professional services.

B. An issuer may not require a dentist to use any other code other than the CDT-1 codes for the initial filing of claims for dental care services.

C. Use of J512 Form shall be effective July 1, 1994 for all issuers excluding reimbursement to dentists reimbursed by Louisiana Medicaid which shall have an effective date of January 1, 1995.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2313. General Provisions

A. A health care provider or institutional care provider shall file a claim in a manner consistent with the requirements of this regulation which are:

1. a paper form printed on 8.5-inch paper;

2. an electronically transmitted claim.

B. An issuer shall accept a form which is submitted in compliance with this regulation for the processing of the insured's or beneficiaries' claims.

C. Nothing in this regulation shall prevent an issuer from requesting additional information which is not contained on the forms required under this regulation to determine eligibility of the claim for payment if required under the terms of the policy or certificate issued to the claimant.

D. All health care providers and institutional care providers shall:

1. use the most current editions of the HCFA approved Form 1500, HCFA Form UB92, or J512 Form and most current instructions for these forms in the billing of patients or their representatives and filing claims with issuers;

2. modify their billing practices to encompass the coding charges for all billing and claim filing by the effective date of the changes set forth by the developers of the forms, codes, and procedures required under this regulation.

E. Submitted billing and claim filing forms not complying with the minimum requirements of this regulation shall be considered to be in noncompliance with the regulation and issuers shall have the right to deny reimbursement until such time as the forms are in compliance with this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code.*
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

Chapter 25. Regulation 49—Billing Audit Guidelines

§2501. Purpose

A. The purpose of this regulation is to provide for the reasonable standardization of statewide billing audit guidelines for health care providers and payers; and to provide for related matters. These rules are based, at least in part, on the National Health Care Billing Audit Guidelines and variances in order to comply with R.S. 22:12.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.
HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).