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).

§2503. Applicability and Scope

A. This regulation shall apply to health care providers and payers. The provider and/or payer involved in the billing audit shall be responsible for the conduct and results of the billing audit, whether conducted by an employee or by contract with another firm. This means that the provider and payer shall:

1. exercise proper supervision of the process to ensure that the audit is conducted according to the spirit of the regulations set forth here;

2. be aware of the actions being undertaken by the auditor in connection with the billing audit and its related activities; and

3. take prompt remedial action if inappropriate behavior by the auditor is discovered.

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).

§2505. Definitions

A. For purposes of this regulation:

Ambulatory Surgical Center—ambulatory surgical center as defined in R.S. 40:2133(A).

Billing Audit—a process to determine whether data in a provider's medical record documents or supports services listed on a provider's bill. Billing audit does not mean a review of medical necessity of services provided, cost or pricing policy of a facility, and adjustments for "usual and customary".

Health Record which Shall Mean Medical Record—any compilation of charts, records, reports, documents, and other memoranda prepared by a health care provider, wherever located, to record or indicate the past or present condition, sickness, or disease, and treatment rendered, physical or mental, of a patient.

Historic Error Rate—the average error found during all audits conducted by external qualified billing auditors during the preceding calendar year. It shall be calculated by totaling the net adjustments made to all accounts audited by external qualified billing auditors during that year and dividing that total by the total amount claimed by the audited party to be due on those accounts immediately preceding the audit. This calculation results is an average error rate for all externally audited cases expressed as a percentage.

Hospital—hospital as defined in R.S. 40:2102(A).

Patient—a natural person who receives or should have received health care from a health care provider, under a contract, expressed or implied.

Qualified Billing Auditor—a person employed by a corporation or firm that is recognized as competent to perform or coordinate billing audits and that has explicit policies and procedures protecting the confidentiality of all the patient information in their possession and disposal of this information.

Unbilled Charges—the volume of services indicated on a bill is less than the volume identified in a provider's health record documentation; also known as undercharges.

Unsupported or Undocumented Charges—the volume of services indicated on a bill exceeds the total volume identified in a provider's health record documentation; also known as overcharges.

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).

§2507. Qualifications of Auditors and Audit Coordinators

A. All persons performing billing audits, as well as persons functioning as provider audit coordinators, shall have appropriate knowledge, experience, and/or expertise in a number of areas of health care including, but not limited to, the following areas:

1. format and content of the health record as well as other forms of medical/clinical documentation;

2. generally accepted auditing principles and practices as they may apply to billing audits;

3. billing claims forms, including the UB-82 and UB 92, the HCFA 1500, and charging and billing procedures;

4. all state and federal regulations concerning the use, disclosure, and confidentiality of all patient records; and

5. specific critical care units, specialty areas, and/or ancillary units involved in a particular audit.

B. Providers or payers who encounter audit personnel who do not meet these qualifications shall immediately contact the auditor's firm or sponsoring party, but may not request information unrelated to the areas listed in §2507.A.

C. Audit personnel shall be able to work with a variety of health care personnel and patients. They shall always conduct themselves in an acceptable, professional manner and adhere to ethical standards, confidentiality requirements, and objectivity. They shall completely document their findings and problems.

D. All unsupported or unbilled charges identified in the course of an audit must be documented in the audit report by the auditor. Individual audit personnel shall not be placed in a situation through their remuneration, benefits, contingency fees, or other instructions that would call their findings into question. In other words, compensation of audit personnel shall be structured so that it does not create any incentives to produce questionable audit findings. Providers or payers who encounter an individual who appears to be involved in a conflict of interest shall contact the appropriate management of the sponsoring organization.

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).

§2509. Notification of Audit

A. Payers and providers shall make every effort to resolve billing inquiries directly. To support this process, the name and contact telephone number (and/or facsimile number) of each payer or provider representative shall be exchanged no later than the time of billing for a provider and the point of first inquiry by a payer.

B. If a satisfactory resolution of the questions surrounding the bill is not achieved by payer and provider representatives, then a full audit process may be initiated by the payer.

C. Generally, billing audits require documentation from or review of a patient's health record and other similar medical/clinical documentation. Health records exist primarily to ensure continuity of care for a patient; therefore, the use of a patient's record for an audit must be secondary to its use in patient care.

D. To alleviate the potential conflict with clinical uses of the health record and to reduce the cost of conducting a necessary audit, all payer billing audits shall begin with a notification to the provider of an intent to audit. Notification of the provider by the qualified billing auditor shall occur no later than four months following receipt of the final bill by the payer. Once notified, the provider shall respond to the qualified billing auditor within one month with a schedule for the conduct of the audit. The qualified billing auditor shall complete the audit within six months of receipt of the final bill by the payer. When there is a substantial and continuing relationship between a payer and a provider, this relationship may warrant a notification, response, and audit schedule other than that outlined herein. Also, each party shall make reasonable provisions to accommodate circumstances in which the schedule specified herein cannot be met by the other party.

E. All billing audits shall be conducted "on site."

F. All requests, whether telephonically or written, for billing audits shall include the following information:

1. the basis of the payer's intent to conduct an audit on a particular bill or group of bills (when the intent is to audit only specific charges or portions of the bill(s), this information should be included in the notification request);

2. name of the patient;

3. admit and discharge dates;

4. name of the auditor and the name of the audit firm;

5. medical record number and provider's patient account number; and

6. whom to contact at the payer institution and, if applicable, at the agent institution to discuss this request and schedule the audit.

G. Providers who cannot accommodate an audit request that conforms with these guidelines shall explain why the request cannot be met by the provider in a reasonable period of time. Auditors shall group audits to increase efficiency whenever possible.

1. If a provider believes an auditor will have problems accessing records, the provider shall notify the auditor prior to the scheduled date of audit. Providers shall supply the auditor/payer with any information that could affect the efficiency of the audit once the auditor is on site.

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).

§2511. Provider Audit Coordinators

A. Providers shall designate an individual to coordinate all billing audit activities. An audit coordinator shall have the same qualifications as an auditor (see §2507, Qualifications of Auditors and Audit Coordinators). Duties of an audit coordinator include, but are not limited to, the coordination of the following areas:

1. scheduling an audit;

2. advising other provider personnel/departments of a pending audit;

3. ensure that the condition of admission is part of the medical record;

4. verifying that the auditor is an authorized representative of the payer;

5. gathering the necessary documents for the audit;

6. coordinating auditor requests for information, space in which to conduct an audit, and access to records and provider personnel;

7. orienting auditors to hospital audit procedures, record documentation conventions, and billing practices;

8. acting as a liaison between the auditor and other hospital personnel;

9. conducting an exit interview with the auditor to answer questions and review audit findings;

10. reviewing the auditor's final written report and following up on any charges still in dispute;

11. arranging for payment as applicable; and

12. arranging for any required adjustment to bills or refunds.

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).

§2513. Conditions and Scheduling of Audits

A. In order to have a fair, efficient, and effective audit process, providers and payer auditors shall adhere to the following requirements:

1. whatever the original intended purpose of the billing audit, all parties shall agree to recognize, record, or present any identified unsupported or unbilled charges discovered by the audit parties;

2. late billing shall not be precluded by the scheduling of an audit;

3. the parties involved in the audit shall mutually agree to set and adhere to a predetermined time frame for the resolution of any discrepancies, questions, or errors that surface in the audit;

4. an exit conference and a written report shall be part of each audit. If the provider waives the exit conference, the auditor shall note that action in the written report. The specific content of the final report shall be restricted to those parties involved in the audit;

5. if the provider decides to contest the findings, the auditor shall be informed immediately;

6. once both parties agree to the audit findings, audit results are final;

7. all personnel involved shall maintain a professional courteous manner and resolve all misunderstandings amicably; and

8. at times, the audit will note ongoing problems either with the billing or documentation process. When this situation occurs, and it cannot be corrected as part of the exit process, the management of the provider or payer organization shall be contacted to identify the situation and take appropriate steps to resolve the identified problem. Parties to an audit shall eliminate ongoing problems or questions whenever possible as part of the audit process.

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).

§2515. Confidentiality and Authorizations

A. All parties to a billing audit shall comply with all federal and state laws and any contractual agreements regarding the confidentiality of patient information.

B. The release of medical records requires authorization from the patient. Such authorization shall be provided for in the condition of admission, or equivalent statement, procured by the hospital or ambulatory surgical center upon admission of the patient. If no such statement is obtained, an authorization for a billing audit shall be required. Authorization need not be specific to the insurer or auditor conducting the audit.

C. Such authorization shall be obtained by the billing audit firm or payer and shall include:

1. the name of the payer, and if applicable, the name of the audit firm that is to receive the information;

2. the name of the institution that is to release the information;

3. the full name, birth date, and address of the patient whose records are to be released;

4. the extent or nature of the information to be released, with inclusive dates of treatment; and

5. the provider's patient account number; and

6. the signature of the patient or his legal representative and the date the consent is signed.

D. A patient's assignment of benefits shall include a presumption of authorization to review records.

E. The audit coordinator or medical records representative shall confirm for the audit representative that a condition of admission statement is available for the particular audit that needs scheduling.

F. The provider will inform the requestor, on a timely basis, if there are any federal or state laws prohibiting or restricting review of the medical record and if there are institutional confidentiality policies and procedure affecting the review. These institutional confidentiality policies shall not be specifically oriented in order to delay an external audit.

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).

§2517. Documentation

A. Verification of charges will include the investigation of whether or not:

1. charges are reported on the bill accurately;

2. services are documented in health or other appropriate records as having been rendered to the patient; and

3. services were delivered by the institution in compliance with the physician's plan of treatment. (In appropriate situations, professional staff may provide supplies or follow procedures that are in accordance with established institutional policies, procedures, or professional licensure standards. Many procedures include items that are not specifically documented in a record but are referenced in medical or clinical policies. All such policies should be reviewed, approved, and documented as required by the Joint Commission on Accreditation of Health Care Organizations or other accreditation of health care organizations or other accreditation agencies. Policies should be available for review by the auditor.)

B. The health record documents clinical data on diagnoses, treatments, and outcomes. It was not designed to be a billing document. A patient health record generally documents pertinent information related to care. The health record may not back up each individual charge on the patient bill. Other signed documentation for services provided to the patient may exist within the provider's ancillary departments in the form of department treatment logs, daily records, individual service/order tickets, and other documents.

C. Auditors may have to review a number of other documents to determine valid charges. Auditors must recognize that these sources of information are accepted as reasonable evidence that the services ordered by the physician were actually provided to the patient. Providers

must ensure that proper policies and procedures exist to specify what documentation and authorization must be in the health record and in the ancillary records and/or logs. These procedures document that services have been properly ordered for and delivered to patients. When sources other than the health record are providing such documentation, the provider shall notify the auditor and make those sources available to the auditor.

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).

§2519. Fees and Payments

A. Payment of a bill shall be made promptly and shall not be delayed by an audit process. Payment on a submitted bill from a third party payer shall be based on amounts billed and covered by the patient's benefit plan.

B. Billing audits shall be made in accordance with one of the following three audit fee and payment schedules:

1. a $100 audit fee shall be paid by the auditor to the audited party. Such audited party shall not require payment greater than 100 percent of the audited party's submitted bill minus such party's historic error rate;

2. in those instances where the audited party has had less than 12 audits in a calendar year, the error rate shall be set by mutual agreement between the audited party and the qualified billing auditor; and when the parties cannot agree, then the historic error rate shall be presumed to be 7 percent; and

3. the $100 fee shall be waived in the following scenarios:

a. payment of 100 percent of the covered benefit plan has been made; or

b. the on site audit commencement date exceeds 60 days from the date of the request for audit; or

c. audit fees are not required or are otherwise being waived.

C. Each provider's billing audit coordinator shall maintain a log containing the results of all audits performed by external qualified billing auditors in the preceding 24 months. In cases where the log is not complete for the past 24 months, the error rate shall be set by mutual agreement between the audited party and the qualified billing auditor; and when the parties cannot agree, then the historic error rate shall be presumed to be seven percent.

D. The audit log shall contain the amount billed immediately preceding the audit, and net adjustment resulting from the audit, the name, address, and phone number of the audit firm conducting the audit, and the name of the qualified billing auditor who performed the audit. Audits whose results are in dispute and audits ordered by the provider and conducted by its own or contracted audit organization shall not be included in the audit log. The audit log shall be available at all times during regular business hours for inspection by any qualified billing auditor.

E. Audit fees, if needed, are to be paid upon commencement of the on site billing audit. Any payment identified in the audit results that is owed to either party by the other shall be settled by the audit parties within a reasonable period of time-not to exceed 30 days after completion of the audit unless the two parties agree otherwise.

F. Neither the provider nor the qualified billing auditor shall require a billing, or re-billing, or refund request following final audit determination, but all findings shall be netted, and the final result will be due by the relevant party without additional billing.

G. Photocopying and duplication charges shall be paid in accordance with R.S. 40:1299.96.

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).

Chapter 27. Regulation 51—Individual Health Insurance Rating Requirements

§2701. Purpose

A. The purpose of this rule is to facilitate the implementation of R.S. 22:228.6. The intent of R.S. 22:228.6 is to establish a modified community rating system for health care premiums in the state. Adherence to this rule by individual health and accident insurance carriers will bring carriers into compliance with R.S. 22:228.6. The provisions of R.S. 22:228.6 not specifically addressed in this rule are in full force and effect as if they were addressed herein.

AUTHORITY NOTE: Promulgated in accordance with Act 655 of the 1993 Regular Legislative Session and R.S. 22:10 and 22:228.6.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:314 (March 1994), amended LR 21:1338 (December 1995).

§2703. Applicability and Scope

A. R.S. 22:228.6 applies to the rating of small group and individual health benefit plans. This particular regulation applies to the compliance of individual health benefit plans only.

AUTHORITY NOTE: Promulgated in accordance with Act 655 of the 1993 Regular Legislative Session and R.S. 22:10 and 22:228.6.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:314 (March 1994), amended LR 21:1338 (December 1995).

§2705. Definitions

Individual Policy—any hospital, health or medical expense insurance policy, hospital or medical services contract, health and accident insurance policy, or any other insurance contract of this type covering any one person with or without eligible family members. Not included under this definition are continuation or conversion policies, or