PLANS A & B

ATTACHED

LOUISIANA MANDATED SERVICE CHARGES

LOUISIANA HEALTH PLAN

"Louisiana Mandated Service Charge Information & Coding"

Table of Contents

About Louisiana Health Plan

The Louisiana Health Plan (LHP), formerly known as the Louisiana Health Insurance Association (LHIA), was created in 1990 and was effectuated in January of 1991. La. R.S. 22:213.2 and 22:231 et. seq.

The High Risk Pool was initially created to provide health insurance policies to those persons who cannot obtain private health insurance because of pre-existing medical conditions (and who are not eligible for Medicare, Medicaid or major medical health coverage).

Additionally, LHP administers the HIPAA plan, which became effective January 1, 1998.

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). The law is intended to make coverage from one group employment situation to another more "portable". The HIPAA program is designed to provide coverage to those persons who move from eligible group coverage into the individual market.

In 1997, the Louisiana Legislature enacted Act 1154 at the recommendation of the Commissioner of Insurance and the Louisiana Health Care Commission. This law authorized LHP to establish the HIPAA Plan as the “alternative mechanism” in the individual health insurance market for the State of Louisiana.

The Board of Directors and staff of the Louisiana Health Plan, along with the Department of Insurance, have worked diligently to ensure that the HIPAA program continues to meet all necessary federal requirements. This includes new policies, premiums, and eligibility requirements to comply with the federal law.

The HIPAA Plan has a separate funding mechanism through assessment of insurance carriers, Health Maintenance Organizations (HMOs), and stop-loss and excess carriers doing business in the state of Louisiana. The HIPAA pool has unlimited enrollment due to federal requirements.

About the Louisiana Mandated Service Charge

The Louisiana Mandated Service Charge (LMSC) was implemented in 1991 with the creation of Louisiana Health Plan (LHP) to act as a funding mechanism for the Louisiana High Risk Pool. Louisiana Health Plan is the recipient of the LMSC imposed on inpatient and outpatient hospital and surgical facilities under La. R.S. 22:239 and 22:241. The following details the LMSC Plan:

I. Louisiana Mandated Service Charge Plan

A. Service Charges

Mandated service charges under 22:213.2 et seq shall be paid by the insurer or insurance arrangement directly to the Louisiana Health Plan. The insurer or insurance arrangement shall be responsible for remitting the payments to LHP. Payment shall be made by check made payable to **Louisiana Health Plan. The monthly report shall be attached thereto and shall clearly state the information required under Section (F) Insurer Report for each remittance. Payment and reports shall be mailed to LHP within (30) days** of the end of the previous calendar month. Payments shall be made for all claims paid during the previous calendar month.

B. Definitions

The following terms shall have the following meaning:

a. "LHP" refers to the Louisiana Health Plan.

b. "Covered service" means an eligible inpatient day or an eligible outpatient admission.

c. "Eligible inpatient day" means any day in which an eligible outpatient, including a newborn, is charged a room or nursery room charge for an overnight stay in a hospital, except when the stay is for psychiatric care or treatment of alcohol or substance abuse.

d. “Eligible outpatient admission” means, with regard to hospitals, and admission for either ambulatory surgical care or endoscopic procedure for which no charge for an overnight stay is made and, with regard to licensed ambulatory surgery centers, any admission.

e. “Eligible patient” means all patients **except** the following:

(1) Private pay patient;
(2) Patients covered by any entitlement program contained in the Social Security Act;
(3) Patients covered by Civilian Health and Medical Program of the Uniformed Services (CHAMPUS);
(4) Patients covered by programs administered by the Department of Veterans Affairs or the Department of Defense;
(5) Patients covered by other pgrograms administered or funded by the United States of America;
(6) Patients covered by the State Employees Group Benefit program; and
(7) Patients covered by insolvent insurers.

f. “Fee” means the service charge provided in R.S. 22:239, being two dollars ($2) per eligible inpatient day and one dollar ($1) per eligible outpatient admission.

g. “Hospital” means a hospital licensed under R.S. 40:2102, excluding those owned, operated or created by the state, the Department of Veterans Affairs or other agency of the United States of America, or any facility operated solely to provide psychiatric care or treatment of alcohol or substance abuse.

h. “Insurer” means the person or entity defined as an “insurance arrangement” in R.S. 22:232 (1), defined as an “insurer” R.S. 22:232 (12), or defined as a “self-insured” in R.S. 22:232 (17) and which, subject to the exceptions contained in R.S. 22:231 et seq, is responsible for payment of the fee to the provider as specified in R.S. 22:239 (D). In the event of dual coverage, the primary carrier is responsible for the fee.

i. “Licensed ambulatory surgery center” means an ambulatory surgery center licensed under R.S. 40:2131 et seq.

j. “Private pay patient” means a natural person whose inpatient day or outpatient admission is not covered by any policy or plan of insurance or by a self-insurer or whose charge for injury or illness are not compensable by his employer or other insurance arrangement.

k. “Providers” means hospitals and licensed ambulatory surgery centers.

C. Billing / Coding

Prior to January 01, 2005:

The provider shall bill every eligible patient for the Louisiana Mandated Service Charge. In the past we have used a “071 revenue code” on the UB-92 for facilities to bill and payors to pay the LMSC. Under the HIPAA Transaction and Code Set (TSC) regulations, revenue code 071 could no longer be used for electronically filed claims. As an alternative solution, Providers and their Clearinghouses, were instructed to us the “Facility Tax Amount” field on electronic claims. The ‘Facility Tax Amount’ is reported in the AMT segment of Loop 2400 in the HIPAA standard transaction referred to as the 837I.

After consulting with the National Uniform Billing Committee it was determined that this alternative method was inappropriate. Therefore, the following coding method shall be utilized beginning January 01, 2005.

Beginning January 01, 2005:

The provider shall bill every eligible patient for the Louisiana Mandated Service Charge. Beginning January 01, 2005 the LMSC shall be coded using national value codes ‘AA’, ‘BA’, and ‘CA’ reported in the HI segment of loop 2300 in the 837I using the qualifier code of ‘BE’. These codes are defined as Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes for Payer A (AA), Payer B (BA), and Payer C (CA).

D. Insurer Remittance

Insurers and insurance arrangements shall pay the billed fees directly to the Louisiana Health Plan and shall include the report required in Section (F) with the remittance.

Remittance shall be made payable to the Louisiana Health Plan and mailed to the following address:

Louisiana Health Plan
P. O. Drawer 83880
Baton Rouge, LA 70884-3880

E. Provider Report

Providers shall report, within 15 days at the end of each calendar month, all fees billed during the preceding calendar month. The report shall include the name of the insurer, name of the insured, patient identification number, policy number, claimant name, address, service dates, and total service charges billed. A grand total of all fees billed shall also be provided. The report shall be made in a format as shown on the following Attachment B. Exceptions may be permitted by LHP to these requirements if written submissions are made at least 15 days prior to the next regularly scheduled Board of Directors Meeting. Requests for exceptions shall clearly define what payments, report submissions, and other pertinent information will be supplied for audit purposes. Additionally, providers shall keep, for not less than three years and with regard to every patient for which a fee has been paid all records necessary to identify the patient, the dates of admission or other unique patient identifier, and the patient's insurance status including company name, address, and policy number. **Reporting is preferred electronically in an Excel spreadsheet.**

F. Insurer Report

Insurers shall report to LHP within (30) days of the end of the calendar month, all fees paid during the previous calendar month. The report shall identify the provider, patient, insured, claimant, policy number, service dates, paid or denial status, total service charges billed and total services charges paid. The report shall be made in a format as shown on the following Attachment B. Exceptions may be permitted by LHP to these requirements if written submissions are made at least 15 days prior to the next regularly scheduled Board of Directors Meeting. Requests for exceptions shall clearly define what payments, report submissions, and other pertinent information will be supplied for audit purposes. **Reporting is preferred electronically in an Excel spreadsheet.**

G. Delinquent Payment from Insurers

a. The Louisiana Health Plan shall have the option of either collecting delinquent fees themselves or assigning those fees to the Commissioner of Insurance to pursue collection, in addition to all other powers granted the Commissioner against the insurer. Such an assignment shall be on a form approved by the Commissioner and may be general and prospective.

b. When an insurer is delinquent in reporting and/or payment to LHP, LHP shall cause the matter to be placed on the agenda of the Board of LHP for hearing. The Board shall send to the insurer, by certified mail, notice of the hearing at least thirty days prior to thereto. The insurer may be represented by an attorney at the hearing.

c. If the Board fails to render its decision at the hearing, it shall notify the insurer of its decision by certified mail. The insurer shall then have (20) days to accept or reject the assessment. If the insurer accepts the assessment, it shall pay LHP within (30) days all penalties due. If the insurer rejects the assessment, LHP may enforce it by suit filed in proper venue. In such a suit in which the insurer has been found to have committed three or more violations within a six month period, the court shall award to LHP reasonable attorney fees.

H. Delinquent Report from Providers

a. When a provider is delinquent and/or fails to bill and/or report to LHP, LHP shall cause the matter to be placed on the agenda of the Board of LHP for hearing. The Board shall send to the provider, by certified mail, notice of the hearing at least thirty days prior thereto. The provider may be represented by an attorney at the hearing.

b. In assessing penalties, the Board shall consider the provider's reasons for not billing and/or reporting, its history of reporting, such other fact as shall appear relevant.

c. If the Board fails to render its decision at the hearing, it shall notify the provider of its decision by certified mail. The provider shall then have (20) days to accept or reject the assessment. If the provider accepts the assessment, it shall pay LHP within thirty (30) days all penalties due. If the provider rejects the assessment, LHP may enforce it by suit filed in proper venue. In such a suit, the court shall award interest at the legal rate on all penalties from date due until paid, along with court costs. In such a suit in which the provider has been found to have committed three or more violations with a six-month period, the court shall also award to LHP reasonable attorney fees.

I. Audits

Pursuant to R.S. 22:213.2, the Louisiana Health Plan, the commissioner, or both, are specifically authorized to conduct audits of insurers or insurance arrangements in order to enforce compliance with the Louisiana Mandated Service Charge.

LMSC Coding Issue

In the past, providers were required to use revenue code '071' on electronic and hardcopy UB-92 claims when reporting the LMSC. Payors were required to report and submit payments to the LMSC for charges billed with revenue code 071.

Under the HIPAA Transaction and Code Set (TSC) regulations, revenue code 071 could no longer be used for electronically filed claims. As an alternative solution, Providers and their Clearinghouses, were instructed to us the "Facility Tax Amount" field on electronic claims. The 'Facility Tax Amount' is reported in the AMT segment of Loop 2400 in the HIPAA standard transaction referred to as the 837I.

After consulting with the National Uniform Billing Committee it was determined that this alternative method was inappropriate.

National Uniform Billing Committee's Recommendation

(See Attachments 1 & 2 for NUBC meeting minutes & summary)

During their February 24-25, 2003 meeting, the NUBC approved several new Value Codes to be used for the reporting of the LMSC (see NUBC Meeting Minutes). The new Value Codes are 'AA', 'BA' and 'CA'. These codes are defined as 'Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes for Payer A (AA), Payer B (BA) and Payer C (CA). Value Codes are reported in the HI segment of loop 2300 in the 837I using a qualifier code of 'BE'.

The use of these new Value Codes will allow for consistency between electronic and paper claims filing, as well as achieving compliance under the HIPAA and NUBC guidelines.

Implementation of New Coding for LMSC

The start date for using the new value codes for billing and paying the LMSC is January 1, 2005. All claims with submission dates on or after January 1, 2005 shall incorporate the new value codes for LMSC billing and paying. Providers & Insurers will be notified of these changes.

Additional Resources

Louisiana Health Plan - www.lahealthplan.org
1-800-736-0947
(225) 926-6245

Rountree & Associates - www.rountree-inc.com
(985) 892-5343

National Uniform Billing Committee - www.nubc.org

Louisiana Department of Insurance - www.ldi.state.la.us
(225) 342-5900

Louisiana State Legislature - www.legis.state.la.us

Louisiana Mandated Service Charge Reporting Formats

Reporting is preferred electronically in an Excel spreadsheet.

Provider Report Format:

Health Care Provider Name
Address
Tax ID#
Reporting Period (From - To)

Insurance Co./ Third Party Administrator/ Employer Name	Insured	Patient #	Policy#	Claimant	Address				Dates of Service	Total Billed
					Street	City	State	Zip		
Total										**$ -**

Insurer Report Format:

Insurance Co./ Third Party Administrator/ Employer Name
Address
Tax ID#
Reporting Period (From - To)

Health Care Provider Name	Insured	Patient #	Policy#	Claimant	Address				Dates of Service	Paid (P) Denied	Total Billed	Total Paid
					Street	City	State	Zip				
Total											**$ -**	**$ -**

*If Denied: Give Reason for full or partial Denial
For Example:
(1) Cosmetic Surgery; No Coverage
(2) No Coverage