Title 40

Labor and Employment

Part 1. Workers' Compensation Administration

Chapter 3. Electronic Billing

§ 301. Purpose

The purpose of this Rule is to provide a legal framework for electronic billing, processing, and payment of medical services and products provided to an injured employee and data reporting subject to RS 23:1203.2. It is the goal of the OWCA that electronic billing in Louisiana will follow formats that adhere to National Standards and Industry practices so as to minimize any customization specific to Louisiana. However, electronic billing in the workers compensation environment requires additional consideration for the required medical records (electronic attachments). At the time of promulgation, electronic attachments are not commonly used outside of the workers compensation environment. While the purpose of RS 23:1203.2 and these accompanying rules are to implement electronic billing in Louisiana, it is recognized that not all healthcare providers will immediately have the systems and processes to accommodate electronic billing and electronic attachments; therefore, participation in electronic medical billing as established in these rules is consistent with RS 23:1203.2 and is voluntary for healthcare providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.2.

ISTORICAL NOTE: Promulgated by the La. Workforce Commission, Office of Workers' Compensation LR

§ 303. Definitions

A. For the purposes of this Rule the following definitions shall apply:

Agent—broadly construed to mean any person or entity that performs medical bill related processes for the insurance carrier responsible for the bill. These processes include, but are not limited to, reporting to government agencies, electronic transmission, forwarding, or receipt of documents, review of reports, adjudication of bill, and final payment.

Business Day—Monday through Friday, excluding days on which a holiday is observed by this state.

Clearinghouse—a public or private entity, including a billing service, re-pricing company, community health management information system or community health information system, and "value-added" networks and switches, that is an agent of either the insurance carrier or provider and may perform the following functions:

a. Processes or facilitates the processing of medical billing information received from a client in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction for further processing of a bill related transaction; or

b. Receives a standard transaction from another entity and processes or facilitates the processing of medical billing information into nonstandard format or nonstandard data content for a client entity.

Complete Electronic Medical Bill —a medical bill that meets all of the following criteria:

a. it is submitted in the correct uniform billing format, with the correct uniform billing code sets, transmitted in compliance with the format requirements described in this rule;

b. the bill and electronic attachments provide all information required under RS 23: 1203.2 and ;

c. the health care provider has provided all information that insurance carrier requested under Title 40 of the Louisiana Administrative Code for purposes of processing the bill.

CMS—the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

*Electronic Medical Billing and Payment Companion Guid*e— a separate document which gives detailed information for electronic billing and payment. The guide outlines the workers' compensation industry national standards and Louisiana jurisdictional procedures necessary for engaging in Electronic Data Interchange (EDI) and specifies clarifications where applicable.

Electronic—a communication between computerized data exchange systems that complies with the standards enumerated in this rule.

Health Care Provider—is defined in R.S. 23:1021.

Health Care Provider Agent—a person or entity that contracts with a health care provider establishing an agency relationship to process bills for services provided by the health care provider under the terms and conditions of a contract between the agent and health care provider. Such contracts may permit the agent to submit bills, request reconsideration, and receive reimbursement for the health care provider services billed.

Implementation Guide—a published document for national electronic standard formats as defined in Section 3 of this rule that specifies data requirements and data transaction sets.

Insurance Carrier—the insurer legally responsible for paying the medical bills under workers' compensation, or an agent of this entity.

National Provider Identification Number or NPI—the unique identifier assigned to a health care provider or health care facility by the Secretary of the United States Department of Health and Human Services.

Supporting Documentation—documents necessary for the insurance carrier or its agent to process a bill. These include, but are not limited to, any records as required by Title 40 of the Louisiana Administrative Code.

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HISTORICAL NOTE: Promulgated by the La. Workforce Commission, Office of Workers' Compensation LR

§305. Formats for Electronic Medical Bill Processing

A. Where mandated for insurance carriers, beginning July 1, 2013 for electronic transmissions, the following electronic medical bill processing standards shall be used.

1. Billing

a. Professional Billing -- the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Professional (837), May 2006, ASC X12, 005010X222 and Type 3 Errata to Health Care Claim: Professional (837), June 2010, ASC X12, 005010X222A1.

b. Institutional/Hospital Billing -- the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Institutional (837), May 2006, ASC X12N/005010X223, Type 1 Errata to Health Care Claim: Institutional (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October

2007, ASC X12N/005010X223A1, and Type 3 Errata to Health Care Claim: Institutional (837), June 2010, ASC X12, 005010X223A2.

c. Dental Billing--the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Dental (837), May 2006, ASC X12N/005010X224, Type 1 Errata to Health Care Claim: Dental (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12N/005010X224A1, and Type 3 Errata to Health Care Claim: Dental (837), June 2010, ASC X12, 005010X224A2.

d. Retail Pharmacy Billing -- the Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, National Council for Prescription Drug Programs and the Batch Standard Batch Implementation Guide, Version 1, Release 2 (Version 1.2), January 2006, National Council for Prescription Drug Programs.

2. Acknowledgment

a. Electronic responses to ASC X12N 837 transactions:

i. the ASC X12 Standards for Electronic Data Interchange TA1 Interchange Acknowledgment contained in the standards adopted under subsection (A)(1) of this section;

ii. the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Implementation Acknowledgment for Health Care Insurance (999), June 2007, ASC X12N/005010X231; and

iii. the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim Acknowledgment (277CA), January 2007, ASC X12N/005010X214.

b. Electronic responses to NCPDP transactions:

i. the response contained in the standards adopted under Subsection (A)(1) of this section.

3. Remittance -- the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim Payment/Advice (835), April 2006, ASC X12N/005010X221 and Type 3 Errata to Health Care Claim Payment/Advice (835), June 2010, ASC X12, 005010X221A1.

4. Documentation submitted with an electronic medical bill in accordance with Section 5(E) of this title (relating to Medical Documentation): ASC X12N Additional Information to Support a Health Claim or Encounter (275), February 2008, ASC X12, 005010X210.

B. Nothing in this section shall prohibit insurance carriers and health care providers from using a direct data entry methodology for complying with these requirements, provided the methodology complies with the data content requirements of the adopted formats and these rules.

C. Insurance carriers and health care providers may exchange electronic data in a non-prescribed format by mutual agreement. All data elements required in the OWCA-prescribed formats must be present in a mutually agreed upon format.

D. The implementation specifications for the ASC X12N and the ASC X12 Standards for Electronic Data Interchange may be obtained from the ASC X12, 7600 Leesburg Pike, Suite 430, Falls Church, VA 22043; Telephone (703) 970–4480; and FAX (703) 970–4488. They are also available through the Internet at http://store.X12.org. A fee is charged for all implementation specifications.

E. The implementation specifications for the retail pharmacy standards may be obtained from the National Council for Prescription Drug Programs, 9240 East Raintree Drive, Scottsdale, AZ 85260. Telephone (480) 477–1000; FAX (480) 767–1042. They are also available through the Internet at http://www.ncpdp.org. A fee is charged for all implementation specifications.

F. Whenever the formats enumerated in paragraph A for billing, acknowledgement, remittance, and documentation are replaced with a newer version, the most recent standard should be used. The requirement to use a new version shall commence on the effective date of the new version as published in the Code of Federal Regulations.

G. The OWCA shall develop an "Electronic Medical Billing and Payment Companion Guide" by January 1, 2013.

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HISTORICAL NOTE: Promulgated by the La. Workforce Commission, Office of Workers' Compensation LR

§ 307. Billing Code Sets

A. Billing codes and modifier systems identified below are valid codes for these workers' compensation transactions, in addition to any code sets defined by the standards adopted in Section 305.

1. "CDT-4 Codes" - codes and nomenclature prescribed by the American Dental Association.

2. "CPT-4 Codes" -- the procedural terminology and codes contained in the "Current Procedural Terminology, Fourth Edition," as published by the American Medical Association and as adopted in the appropriate fee schedule contained in Title 40 of the Louisiana Administrative Code.

3. "Diagnosis Related Group (DRG)" -- the inpatient classification scheme used by CMS for hospital inpatient reimbursement. The DRG system classifies patients based on principal diagnosis, surgical procedure, age, presence of co-morbidities and complications, and other pertinent data.

4. "HCPCS" --CMS' Healthcare Common Procedure Coding System, a coding system which describes products, supplies, procedures, and health professional services and which includes the American Medical Association's (AMA's) Physician "Current Procedural Terminology, Fourth Edition," (CPT-4) codes, alphanumeric codes, and related modifiers.

5. "ICD-9-CM Codes" -- diagnosis and procedure codes in the International Classification of Diseases, Ninth Revision, Clinical Modification published by the United States Department of Health and Human Services.

6. "ICD-10-CM/PCS Codes" -- diagnosis and procedure codes in the International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System maintained and published by the United States Department of Health and Human Services.

7. "NDC" -- National Drug Codes of the Food and Drug Administration.

8. "Physical Therapy"/"Occupational Therapy Codes" – (PT/OT Codes) – Codes specified in Title 40 of the LAC covering physical therapy and occupational therapy services.

9. "Revenue Codes" -- the four digit coding system developed and maintained by the National Uniform Billing Committee for billing inpatient and outpatient hospital services, home health services, and hospice services.

10. "National Uniform Billing Committee codes"--code structure and instructions established for use by the National Uniform Billing Committee (NUBC), such as occurrence codes, condition codes, or prospective payment indicator codes. These are known as UB 04 Codes.

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HISTORICAL NOTE: Promulgated by the La. Workforce Commission, Office of Workers' Compensation LR

§ 309. Electronic Medical Billing, Reimbursement, and Documentation

A. Applicability

1. This section outlines the exclusive process to exchange electronic medical bill and related payment processing data for professional, institutional/hospital, pharmacy, and dental services. This section does not apply to requests for reconsideration or judicial appeals concerning any matter related to medical compensation or requests for informational copies of medical records.

2. Unless exempted from this process in accordance with Subsection B of this section, insurance carriers or their agents shall:

a. Accept electronic medical bills submitted in accordance with the adopted standards;

b. Transmit acknowledgments and remittance advice in compliance with the adopted standards in response to electronically submitted medical bills; and;

c. Support methods to receive electronic documentation required for the adjudication of a bill, as described in Section 315.

3. If a health care provider elects to utilize electronic medical bill submission, then the healthcare provider shall:

a. Exchange medical bill data in accordance with the adopted standards;

b. Submit medical bills as defined by Section 305A to insurance carriers that have established connectivity to the health care provider’s system or clearinghouse;

c. Submit required documentation in accordance with Subsection E below; and;

d. Receive and process any acceptance or rejection acknowledgment from the insurance carrier.

4. Insurance carriers must be able to exchange electronic data by July 1, 2013 unless exempted from the process in accordance with Subsection B of this section.

5. The insurance carrier’s failure to comply with any requirements of this rule shall result in an administrative violation under LAC 40:109.A.

6. Health care providers who elect not to utilize electronic medical billing pursuant to Paragraph 5(b) shall submit paper medical bills for payment pursuant to Title 40 of the Louisiana Administrative Code.

B. Waivers

1. An insurance carrier is waived from the requirement to receive medical bills electronically from health care providers if:

a. The insurance carrier processed 1200 or fewer medical bills for workers' compensation treatment or services in the previous calendar year.

b. Written requests for waivers shall be submitted to the OWCA at least 90 days prior to the implementation date and renewed for each calendar year thereafter. Approved waivers shall be limited to the calendar year and must be requested in writing 90 days prior to each subsequent calendar year.

c. The OWCA may grant an exception on a case-by-case basis if the insurance carrier establishes that electronic billing will result in an unreasonable financial burden.

C. Notwithstanding any requirements in Section 305, to be considered a complete electronic medical bill, the bill or supporting transmissions must:

1. Include in legible text all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results that are expressly required by Title 40 of the Louisiana Administrative Code.

2. Identify the:

a. injured employee;

b. employer, if available;

c. insurance carrier, third party administrator, managed care organization or its agent;

d. health care provider;

e. medical service or product; and;

f. any other requirements as presented in the electronic billing companion guide as promulgated by the OWCA.

3. Use current and valid codes and values as defined in the applicable formats defined in Sections 305 and 307.

D. Acknowledgment

1. Interchange Acknowledgment (TA1) notifies the sender of the receipt of, and certain structural defects associated with, an incoming transaction.

2. An Implementation . Acknowledgment (ASCX12N999), or the most currently accepted transaction format, is an electronic notification to the sender of the file has been received and has been:

a. accepted as a complete and structurally correct file, or

b. rejected with a valid rejection code.

3. An ASC X12N 277 Health Care Claim Status Response or Acknowledgment transaction (detail acknowledgment) is an electronic notification to the sender of an electronic transaction (individual electronic bill) that the transaction has been received and has been:

a. accepted as a complete, correct submission, or,

b. rejected with a valid rejection code.

4. An insurance carrier must acknowledge receipt of an electronic medical bill by returning an Implementation Acknowledgment (ASCX12N999) within one business day of receipt of the electronic submission.

a. Notification of a rejected bill is transmitted using the appropriate acknowledgment when an electronic medical bill does not meet the definition of a complete electronic medical bill or does not meet the edits defined in the applicable implementation guide or guides.

b. A health care provider or its agent may not submit a duplicate electronic medical bill earlier than 60 business days from the date originally submitted if an insurance carrier has acknowledged acceptance of the original complete electronic medical bill. A health care provider or its agent may submit a corrected electronic medical bill to the insurance carrier after receiving notification of a rejection. The corrected medical bill is submitted as a new, original bill.

5. An insurance carrier must acknowledge receipt of an electronic medical bill by returning an ASC X12N 277 Health Care Claim Status Response or Acknowledgment transaction (detail acknowledgment) within two business days of receipt of the electronic submission.

a. Notification of a rejected bill is transmitted in an ASC X12N 277 response or acknowledgment when an electronic medical bill does not meet the definition of a complete electronic medical bill or does not meet the edits defined in the applicable implementation guide or guides.

b. A health care provider or its agent may not submit a duplicate electronic medical bill earlier than 60 days from the date originally submitted if an insurance carrier has acknowledged acceptance of the original complete electronic medical bill.

6. Acceptance of a complete medical bill is not an admission of liability by the insurance carrier. An insurance carrier may subsequently deny an accepted electronic medical bill if the employer or other responsible party named on the medical bill is not legally liable for its payment.

a. Any subsequent denial of a complete medical bill must occur within the timeframe as provided in RS 23:1201.E from the date of receipt of the complete electronic medical bill.

b. The remittance advice must clearly indicate the reason for the denial.

7. Acceptance of an incomplete medical bill does not satisfy the written notice of injury requirement from an employee or insurance carrier as required in RS 23:1306.

8. Functional acknowledgment under Section 309(D)(3) above, and acceptance of a complete, structurally correct file serves as proof of the received date for an electronic medical bill in Section 309(C).

E. Electronic Documentation

1. Electronic documentation must be submitted with the electronic medical bill.

2. Electronic documentation shall be provided pursuant to Section 309(C).

F. Remittance notification

1. An electronic remittance notification is an explanation of medical benefits (EOMB) or explanation of review (EOR), submitted electronically regarding payment or denial of a medical bill.

2. Upon mutual agreement, an insurance carrier may provide an electronic remittance notification.

3. The electronic remittance notification must contain the appropriate Group Claim Adjustment Reason Codes, Claims Adjustment Reason Codes (CARC) and associated Remittance Advice Remark Codes (RARC) as specified by ASC X12 835N implementation guide or for pharmacy charges, the National Council for Prescription Drugs Program (NCPDP) Reject Codes, denoting the reason for payment, adjustment, or denial.

4. The remittance notification must be released within one business day of the payment or denial.

G. A health care provider or its agent may not submit a duplicate paper medical bill earlier than 60 business days from the date originally submitted unless the insurance carrier has returned the medical bill as incomplete in accordance with Section 311 (Employer, Insurance Carrier, Managed Care Organization, or Agents' Receipt of Medical Bills from Health Care Providers). A health care provider or its agent may submit a corrected electronic medical bill to the insurance carrier after receiving notification of a rejection. The corrected medical bill is submitted as a new, original bill.

H. An insurance carrier or its agent may not reject a standard transaction on the basis that it contains data elements not needed or used by the insurance carrier or its agent.

I. A health care provider that is not able to send a standard transaction may use an Internet-based direct data entry system offered by an insurance carrier if the insurance carrier does not charge a transaction fee. A health care provider using an Internet-based direct data entry system offered by an insurance carrier or other entity must use the appropriate data content and data condition requirements of the standard transactions.

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HISTORICAL NOTE: Promulgated by the La. Workforce Commission, Office of Workers' Compensation LR

§ 311. Employer, Insurance Carrier, Managed Care Organization, or Agents' Receipt of Medical Bills from Health Care Providers

A. Upon receipt of medical bills submitted in accordance with Sections 305, 307, and 309, an insurance carrier shall evaluate each bill's conformance with the criteria of a complete medical bill.

B. The received date of an electronic medical bill is the date all of the contents of a complete electronic bill are successfully received by the insurance carrier.

C. The insurance carrier may contact the medical provider to obtain the information necessary to make the bill complete.

1. Any request by the insurance carrier or its agent for additional documentation to pay a medical bill shall:

a. be made by telephone or electronic transmission or through web portal access if available unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery;

b. be specific to the bill or the bill's related episode of care;

c. describe with specificity the clinical and other information to be included in the response;

d. be relevant and necessary for the resolution of the bill;

e. be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider; and

f. indicate the specific reason for which the insurance carrier is requesting the information.

2. If the insurance carrier or its agent obtains the missing information and completes the bill to the point it can be adjudicated for payment, the insurance carrier shall document the name and telephone number of the person who supplied the information.

D. An insurance carrier shall not return a medical bill except as provided in Subsection A of this section. When returning an ASC X12N 837 medical bill, the insurance carrier shall clearly identify the reason(s) for returning the bill by utilizing the appropriate Reason and Rejection Code identified in the standards identified in Section 305(A)

E. The proper return of an incomplete medical bill in accordance with this section fulfills the obligation of the insurance carrier to provide to the health care provider or its agent information related to the incompleteness of the bill.

F. Insurance carriers must timely reject bills or request additional information needed to reasonably determine the amount payable.

1. For bills submitted electronically, the rejection of all or part of the bill must be sent to the submitter within two business days of receipt.

2. If bills are submitted in a batch transmission, only the specific bills failing edits shall be rejected.

G. If an insurance carrier has reason to challenge the coverage or amount of a specific line item on a bill, but has no reasonable basis for objections to the remainder of the bill, the uncontested portion must be paid timely, as in Subsection H below.

H. Payment of all uncontested portions of a complete medical bill shall be made within 60 business days of receipt of the original bill, or receipt of additional information requested by the insurance carrier allowed under the law. Amounts paid after this 60 calendar day review period shall be subject to LRS 23:1201.F

I. An insurance carrier shall not return a medical bill except as provided in Section 311(A). When returning a medical bill, the insurance carrier shall also communicate the reason(s) for returning the bill.

J. The insurance carrier’s failure to comply with any requirements of this rule shall result in an administrative violation in accordance with LAC 40:109.A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.2.

HISTORICAL NOTE: Promulgated by the La. Workforce Commission, Office of Workers' Compensation LR

§ 313. Communication between Health Care Providers and Insurance Carriers

A. Any communication between the health care provider and the insurance carrier related to medical bill processing shall be of sufficient specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "insurance carrier improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position do not satisfy the requirements of this Section.

B. Utilization of the ASC X12N Reason Codes, or as appropriate, the NCPDP Reject Codes, by the insurance carrier when communicating with the health care provider or its agent or assignee, provides a standard mechanism to communicate issues associated with the medical bill.

C. Communication between the health care provider and insurance carrier related to medical bill processing shall be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery.

D. The insurance carrier’s failure to comply with any requirements of this rule shall result in an administrative violation LAC 40:109.A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.2.

HISTORICAL NOTE: Promulgated by the La. Workforce Commission, Office of Workers' Compensation LR

§ 315. Medical Documentation Necessary for Billing Adjudication

A. Medical documentation includes all medical reports and records permitted or required in accordance with Title 40 of the Louisiana Administrative Code.

B. Any request by the insurance carrier for additional documentation to process a medical bill shall conform to the requirements of Section 311 (C).

C. It is the obligation of insurance carriers to furnish its agents with any documentation necessary for the resolution of a medical bill.

D. Health care providers, health care facilities, third-party biller/assignees, and claims administrators and their agents must comply with all applicable Federal and state rules related to privacy, confidentiality, and security.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.2.

HISTORICAL NOTE: Promulgated by the La. Workforce Commission, Office of Workers' Compensation LR

§ 317. Compliance and Penalty

A. Any electronically submitted bill determined to be complete but not paid or objected to within 60 days shall be subject to penalties per RS 1201.F.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.2.

HISTORICAL NOTE: Promulgated by the La. Workforce Commission, Office of Workers' Compensation LR

§ 319. Effective Date

A. This chapter applies to all medical services and products provided on or after July 1, 2013 for medical services and products provided prior to July 1, 2013, medical billing and processing shall be in accordance with the rules in effect at the time the health care was provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203.2.

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