4. as a result of aviation under conditions specified in the policy;

5. within two years from date of issue of the policy as a result of a specified hazardous occupation or occupations, or while the insured is residing in a specified foreign country or countries, is null and void.

If this policy contains a provision for additional benefit in event of death by accidental means, the conditions and exceptions contained therein shall not be affected by this rider.

In witness whereof, the Company has issued this policy rider effective with the date thereof."

D. It is directed that when present supplies of policies to which this rider is attached have been exhausted, that complete policies, containing all the provisions of the contract, including those provisions contained in the rider, will be sent to this department for approval.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:2 and 22:259.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Commissioner of Insurance, July 24, 1958.

Chapter 60. Regulation 74—Payment of Health Coverage Claims

§6001. Purpose

A. The purpose of this regulation is to implement the statutory requirements of health insurance issuers under Title 22 of the Louisiana Revised Statutes of 1950. Title 22 of the Louisiana Revised Statutes of 1950 establishes the statutory requirements for payment of claims by health insurance issuers serving residents of Louisiana. The statutory requirements establish the intent of the legislature to assure that residents with health care coverage are not billed for liabilities of health insurance.

B. To carry out the intent of the legislature and assure full compliance with the provisions of applicable statutory requirements, this regulation sets forth the standards for payment of claims by health insurance issuers and supercedes current regulations on uniform claim forms.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2006 (September 2000).

§6003. Applicability and Scope

A. Except as otherwise specifically provided, the requirements of this regulation apply to all health insurance coverage issued for delivery in the state of Louisiana that is otherwise subject to the statutory requirements of Part VI-D of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950. The requirements of this regulation apply to all preferred provider organization contracts as required under the provisions of R.S. 40:2203.1(E) of the Louisiana Revised Statutes of 1950. The requirements of this regulation shall also apply to the State Employees Group Benefits Program as required under R.S. 22:230.4(A)(4).

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2006 (September 2000).

§6005. Claim Payments—Definitions

Claim—a request that covered benefits of a health insurance issuer be provided or paid for services that have been provided. The benefits claimed may be in the form of covered services, supplies, payment for all or a portion, of expenses incurred a combination of covered services, supplies and expenses incurred, or indemnification for all or a portion of actual losses.

Claimant—covered person, an authorized representative, or other entity filing a clean claim that is entitled to receive reimbursement from a health insurance issuer for covered benefits.

Clean Claim—a correctly completed standardized claim form as required under the Department of Insurance, Regulation 48.

Commissioner—the Commissioner of Insurance.

Contracted Medical Services—services provided by a state licensed, certified, or state registered provider of health care services, treatment, or supplies, including but not limited to those entities defined in R.S. 40:2203.1 that have entered into a contract or agreement with a health insurance issuer to provide such services, treatment or supplies to an individual enrollee or insured.

Covered Benefits—benefits available to a member, subscriber or insured under an insurance policy, benefit plan, or other contract for coverage of health care benefits. The term also includes any medical services or equipment that is provided to a covered person under an assignment of benefits, when such assignment is authorized by law and the terms of an insurance policy or contract of coverage issued by a health insurance issuer.

Covered Person—an insured, enrollee, member, or subscriber. In the case of a minor, the term includes an insured or legal guardian authorized to act in the best interest of such minor and therefore is acting on behalf of such covered person.

Date Upon Which a Clean Claim is Received—the date the uniform claim form is received by the health insurance issuer or its legal agent. For health insurance issuer examinations, the department will use the postmark date of claims to determine if the date of receipt reasonably reflects the date claims are actually received by health insurance issuers.

Department—the Department of Insurance.

Electronic Claim—the transmission of data for purposes of payment of covered medical services in an electronic data format specified by a health insurance issuer and approved by the department.

Health Insurance Coverage—benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer that is subject to the requirements of Part VI-C of Chapter 1 of the Louisiana Revised Statutes of 1950.

Health Insurance Issuer—an insurance company, including a health maintenance organization, as defined and licensed pursuant to Part XII of Chapter 2 of Title 22, unless preempted as an employee benefit plan covered by the provisions of the Employee Retirement Income Security Act of 1974. The term shall also include the State Employees Group Benefits Program as required under R.S. 22:230.4(A)(4) and preferred provider organizations as required under R.S. 40:2203.

Just and Reasonable Grounds Such as Would Put a Reasonable and Prudent Businessman on His Guard—an articulable set of facts, as opposed to mere speculation or assumption, that fully complies with established jurisprudence. For health insurance issuer examinations, the department will reasonably determine whether denials are based on an articulable set of facts.

Non-Contracted Medical Services—services provided by a state-licensed, certified, or state-registered provider of health care services, treatment, or supplies, including but not limited to those entities defined in R.S. 40:1299.41(A)(1) that have no contract or agreement with a health insurance issuer to provide such services, treatment or supplies to an individual enrollee or insured.

Paid—the date the claim is adjudicated and any amount due and payable is released by the health insurance issuer. Any difference between the date of adjudication and the date the payment is released is required to be documented in the health insurance issuer's claim handling procedures filed with the department.

Prohibited Billing Activities—the demand for payment of medical services from a covered person for covered benefits that are payable under the terms of a provider agreement with a health insurance issuer that is in effect.

Uniform Claim—a standardized claim form as required under the Department of Insurance, Regulation 48.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2007 (September 2000).

§6007. Nonelectronic Claim Submission Standards

A. Contracted Medical Services

1. Any claim submitted by a contracted health care provider within 45 days of the date of service or discharge shall be paid to the claimant not more than 45 days from the date upon which a clean claim is received by a health insurance issuer or its legal agent, for an allowable expense on behalf of a covered person, unless just and reasonable grounds such as would put a reasonable and prudent businessman on his guard exist.

2. Any claim submitted by a health care provider more than 45 days after the date of service or discharge or resubmitted because the original claim was incomplete or incorrect shall be paid to the claimant not more than 60 days from the date upon which a clean claim is received by a health insurance issuer or its legal agent, unless just and reasonable grounds such as would put a reasonable and prudent businessman on his guard exist.

B. Non-Contracted Medical Services

1. Any claim for health insurance coverage benefits, whether submitted for payment by a covered person or by the health care provider rendering covered medical services that are not otherwise payable to the provider under a medical service contract with the health insurance issuer, shall be paid to the claimant not more than 30 days from the date upon which a clean claim is received by a health insurance issuer or its legal agent, unless just and reasonable grounds such as would put a reasonable and prudent businessman on his guard exist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2007 (September 2000).

§6009. Electronic Claim Submission Standards

A. Any clean claim for a covered benefit payable to or on behalf of a covered person submitted by a contracted health care provider as an electronic claim shall be paid to the claimant not more than 25 days from the date upon which a clean claim form is received by the health insurance issuer or its legal agent, unless just and reasonable grounds such as would put a reasonable and prudent businessman on his guard exist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1).

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2008 (September 2000).

§6011. Thirty-Day Payment Standard

A. A health insurance issuer may elect to utilize a 30-day payment standard for compliance with the requirements of §§6007 and 6009 following provision of written notice to the Office of Health Insurance who shall provide notice of such changes. Health insurance issuers may cancel this election upon provision of written notice to the Office of Health Insurance. Any health insurance issuer electing to utilize a 30 day payment standard shall continue to meet all other requirements of this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions: R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2008 (September 2000).

§6013. Claim Handling Procedures

A. Health insurance issuers shall have appropriate handling procedures approved by the department for the acceptance of various claim submissions. Health insurance issuer claim handling procedures shall be filed with the Office of Health Insurance for review and approval. Such procedures shall include:

1. a process for documenting the date of actual receipt of claims. Health insurance issuers shall include appropriate safeguards to assure claims are appropriately classified and directed to the appropriate claims staff for review. The procedures shall include a process for documenting complaints regarding lost claims and appropriate corrective action protocols;

2. a process for reviewing claims for accuracy and acceptability. Health insurance issuers shall document their review process that includes procedures to verify compliance with uniform claim handling procedures. The procedures shall document the reasonable period of time taken to completely review each claim for completeness. The process and average timeframe utilized by the health insurance issuer shall be described in sufficient detail to document the average time required to determine if a uniform claim form has been correctly completed. For any claim that is found to be incomplete or otherwise not payable, the health insurance issuer shall provide specific written notice to the claimant within two days of all known reasons that the claim cannot be processed for payment within a reasonable period of time from the date of reviewing such claim for completeness. The procedures shall assure that the health insurance issuer prohibits the offsetting of claim payments for any other party, except as specifically provided by law, or with the expressed written consent of the claimant or by the contracted medical services provider contract. Except as required under R.S. 40:2010, a health insurance issuer whose policies or contracts of coverage do not allow benefit assignment shall be authorized to reject claims that are incorrectly completed as assigned claims;

3. a process for reporting all claims rejected by the health insurance issuer and the reason for such rejection.

B. Late Payment Procedures. Health insurance issuers shall establish appropriate procedures approved by the department to assure that any claimant who is not paid within the time frames specified in this regulation receives a late payment adjustment equal to 1 percent of the amount due at the time the claim is paid. For any period greater than 25 days following the time frames specified in this regulation, the health insurance issuer shall pay to the claimant an additional late payment adjustment equal to 1 percent of the unpaid balance due for each month or partial month that such claim or any portion of the claim remains unpaid.

C. Compliant Procedures. The health insurance issuer's procedures shall include a process for insureds or enrollees to file complaints regarding provider demands for amounts owed by health insurance issuers. The procedures shall include all actions that will be taken by the health insurance issuer to address non-compliant providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions: R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2008 (September 2000).

§6015. Limitations on Claim Filing and Audits

A. Health insurance issuers that limit the period of time that a claim may be filed for payment of benefits shall have the same limited period of time following payment of such claims to perform any review or audit for purposes of reconsidering the validity of such claims. For example, where a health insurance issuer limits the period for filing a claim for benefits to 12 months, then the health insurance issuer shall be limited to 12 months from the date of payment to perform any review or audit of the claim.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2008 (September 2000).

§6017. Effective Date

A. This regulation shall become effective upon final publication in the *Louisiana Register.*

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:250.35, to implement and enforce the following provisions R.S. 22:230.4(A)(4), Part VI-D of Chapter 1 of the Louisiana Revised Statutes of 1950, and R.S. 40:2203.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 26:2009 (September 2000).

Chapter 61. Regulation 16—Investment by Insurers of Part of Premium Paid, Return Guaranteed

§6101. Policy Directive Number Three to Insurance Companies

A. Effective January 1, 1959, no life insurance policy will be approved for use in the state of Louisiana, which does not guarantee to the policyholder or his or her beneficiary a return of all money, in excess of that part of the gross premium charged for life and disability insurance protection plus any guaranteed coupons, that is, any amount in excess of the net tabular premium, plus the loading for