RATE MANUAL
EFFECTIVE September 2, 2019
LOUISIANA PATIENT'S COMPENSATION FUND

Complete applications are required for all new enrollees and anytime there is a change in class & specialty. Each year thereafter, the one page renewal application must be completed. Please check the PCF website for PCF applications as more have been added and others revised. Applications completed for primary coverage may be used in lieu of the PCF initial applications only.

Copies of certificates can be obtained from the website. Credentialing and claim history request forms along with instructions are also on the website. Frequently asked questions provide further guidance in all areas of the PCF**.**

I. PCF SURCHARGE PAYMENT SCHEDULE

New Enrollees:

Providers with Primary Insurance: Payment must be made on or before the effective date of coverage. If payment is made after the effective date of the primary policy, the PCF effective **date** will be the date the insurance company/agent **received** the payment on behalf of the PCF. Proof of provider's payment may be requested.

Self Insured's: The effective date of coverage is the **date of receipt** by the PCF of the completed application, the appropriate surcharge payment and the security in the amount of $125,000.00.

Renewals:

Providers with Primary Insurance: Payment must be made to the insurance company or agent NO LATER than **30** days after the expiration of the policy.

Self Insured's: Payment must be made to the PCF NO LATER than **30** days after the expiration of the self insured/PCF coverage. However, the completed application, and renewal information for the security must be furnished before a COE will be issued.

Tail Coverage:

Must be purchased from primary and the PCF within **45** days of termination of policy. There are options/exceptions (i.e. retirement, disabled, moving from insurance to self-insurance) for the payment of the PCF tail surcharge and if you feel you may qualify for such you must contact the PCF in writing (email is sufficient).

Tail surcharge cannot be pro-rated unless the provider was insured for less than 8 months. Tail surcharge rate is based on the effective date of the policy that is being cancelled.

Providers that have been part-time three or more years may use the same discount for the PCF tail surcharge. ******Pre-approval is required for discounting the tail surcharge for any provider with less than three years of part-time coverage.

There is no corporate surcharge due for vicarious tail coverage if a PCF enrolled employee leaves the corporation and does not purchase PCF tail.

*******LATE PAYMENT BY THE HEALTHCARE PROVIDER WILL RESULT IN A GAP IN COVERAGE and COULD RESULT IN DENIAL OF COVERAGE ON A CLAIM BY THE PCF.*******

RESPONSIBILITY OF THE INSURANCE COMPANY/AGENT

Once payment is received by the insurance company/agent, the following is remitted to the PCF:

1. A certificate of insurance that includes the complete name and address of the HCP, specialty, license number, date of birth, dates of coverage, **policy type, retro date (if applicable)** and primary premium. *Binders are unacceptable as proof of coverage.*
2. Documentation of any specific exclusions or exceptions to the provider's practice that are not standard to the insurer's policies. Examples would be exclusion of work done at prisons, nursing homes or serving as medical directors, and out of state practices.
3. Insurance policies shall not be subject to a retention or deductible payable by the insured health care provider, with respect to liability, costs of defense or claim adjustment expenses in excess of $25,000.00.
4. Appropriate surcharge payment. If the amount submitted is different from the PCF rate charts or manual, an explanation of the calculation is needed, such as part-time percentage or pro-rated due to length of enrollment.
5. If using the ER per visit rate, you must include a list of locations served and the providers at each location.
6. If using the FTE (full time equivalency or slot) method of calculating the PCF surcharge, you must attach a list of employees included in the count, including average number of hours worked per week. This should be updated quarterly. Minimum FTE is .25 or $250, whichever is greater. If specialty is classified as "other" the PCF surcharge will be 72% of the underlying premium for $100,000/$300,000 coverage or $250 per FTE, whichever is greater. **Please note that the part time discounts cannot be applied to the Full Time Equivalency slot.**
7. In lieu of a COI, a copy of the Declaration Page of the Policy can be sent. If the Declaration Page does not contain all necessary information, such as the provider's date of birth if an individual, the license number, the premium amount if using the "other" percentage rate and the specialty code, this information must be provided in a supplemental memo or cover letter from the insurance company/agent. **Binders are unacceptable as proof of coverage**.
8. Should any delay be anticipated in remittal of any of the required documents or payment, the insurer should immediately contact the PCF to determine the best way to prevent a gap or lapse in PCF coverage.
9. **Failure to provide mandatory documents after the time allowed in any notice from the PCF may result in return of payment and refusal of coverage**.

The PCF does **not** accept insurance binders as proof of underlying coverage. If sent with a PCF surcharge payment, the PCF certificate of enrollment will not be available until the certificate of insurance has been provided. An Acord form can be sent, but **must clearly show whether the policy is a claims made or occurrence policy and must show any applicable retroactive date**.

The insurance company/agent has ***30*** days from the date they receive the payment from a HCP to remit it to the PCF. If remitted past the 30 day period, an insurance company /agent may be charged a **5% penalty + accrued legal interest** from the 31st day until paid. Proof of the primary payment will be requested if a payment is remitted beyond time allowed.

RESPONSIBILITY OF THE SELF INSURED

The following is the responsibility of the self insured when remitting payment to the PCF:

1. Appropriate surcharge payment. If the amount submitted is different from the PCF rate charts or manual, an explanation of the calculation is needed, such as part-time percentage or pro-rated due to length of enrollment.
2. If using the ER per visit rate, you must include a list of locations served and the

providers at each location.

3. If using the FTE (full time equivalency or slot) method of calculating the PCF surcharge, you must attach a list of employees included in the count, including average number of hours worked per week. This should be updated quarterly. Minimum FTE is .25 or $250, whichever is greater. **Please note that the part time discounts cannot be applied to the Full Time Equivalency slot.**
4. Should any delay be anticipated in remittal of any of the required documents or payment, the insured should immediately contact the PCF to determine the best way to prevent a gap or lapse in PCF coverage.
5. **Failure to provide mandatory documents after the time allowed in any notice from the PCF may result in return of payment and refusal of coverage**.

The self insured has ***30*** days from their renewal date to remit payment to the PCF. If remitted past the 30 day period, the self insured could have a gap in coverage.

CANCELLATIONS

Notices of **cancellations** must be received within **30** days of effective date for full refund back to date of cancellation. PCF will determine amount of refund if notice is received more than the 30 days from the effective date. Written justification may be required for full refunds if notice of cancellation is received over **60** days from effective date.

PCF does not accept cancellations directly from finance companies – notice must be from the insurance agent or company. **Refunds** will be made for the current policy only. Refunds will be made where cancellation is for non-renewed policy which terminated within 60 days of request for refund. Refunds are paid to the person or entity that paid the surcharge to the PCF. The PCF reserves the right to request a copy of the Cancellation notice to the provider to ensure compliance with La. R.S. 40:1231.6 D(2) which **requires** a **30 day** written notice to the insured.

II. CLASSIFICATION PROCEDURE:

A. For classification assignment purposes, the following phraseology is defined:

1. The term "**no surgery**" applies to general practitioners and specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia) and who do not ordinarily assist in surgical procedures.
2. The term "**minor surgery**" applies to general practitioners and specialists who perform minor surgery generally use local anesthesia, but not general anesthesia. *additional form required for providers with primary coverage – see *applications – surgical questionnaire PCF 10*.
3. The term "**major surgery**" applies to general practitioners and specialists who perform major surgery or who assist in major surgery on their own or on other than their own patients in which local or general anesthesia or conscious sedation is used. Tonsillectomies, adenoidectomies, abortions, dilation and curettement, laparoscopic procedures, normal obstetrical procedures, cesarean sections and other major invasive procedures shall be considered major surgery. *additional form required for providers with primary coverage – *see applications – surgical questionnaire PCF 10.*

B. When two or more classes are applicable to a general practitioner or specialist, the rate for the **highest** paid class shall apply. This includes assisting in major surgery. Call PCF surcharge section if there is a question regarding classification.

C. Any general practitioner or specialist who would normally be assigned to a class having a code number followed by an asterisk (*) shall be classified and rated as "**Physicians--no major surgery**", code 80534, if any of the following medical techniques or procedures are performed:

a. **Acupuncture**--other than acupuncture anesthesia
b. **Catheterization** -- arterial, cardiac, central venous, or diagnostic, intraluminal angioplasty
c. **Cryosurgery** -- other than use on benign or pre-malignant dermatological lesions
d. **Lasers** -- used in therapy
e. **Shock therapy**
f. **Liposuction**
g. **Skin flaps with arterial blood supply** other than cancer therapy
h. **Any dermatological procedure done under general anesthesia**
i. **Epidural injections** – for pain management **add'l form required for providers with primary coverage – see applications–surgical questionnaire PCF 10.*

D. Any general practitioner or specialist who would normally be assigned to a classification having a code number followed by a cross-hatch (#) shall be classified and rated as "**Physicians –no major surgery**", code 80533, if such general practitioner or specialist performs any of the following medical techniques or procedures:

a. **Catheterization** -- occasional insertion of pulmonary wedge, recording catheters or temporary pacemakers, and umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen.
b. **Needle biopsy** -- including lung, liver, kidney, and prostate.
c. **Radiopaque Dye Injections** into blood vessels, lymphatics, sinus tracts or fistulae (not applicable to Radiologist, Code 80280*).
d. **Pneumatic and mechanical esophageal dilation** (not with bougie or olive). **Additional form required for providers with primary coverage – see applications –surgical questionnaire PCF 10.*

E. **Locum Tenens Coverage:** The PCF requires a surcharge for Locum Tenens. The surcharge is prorated based on the class and specialty of the health care provider who is utilizing the Locum Tenen, or the actual specialty of the Locum Tenen if an employee of a staffing company. **If the policy providing coverage for the locum tenens healthcare provider is claims made the retro date of the policy, not the healthcare provider, must be used.** The surcharge is then calculated based on the number of days worked; however, the PCF requires a minimum surcharge of $250.00. When a health care provider completes the indicated period of time listed on the certificate of insurance, and returns at a later point, he will be required to pay an additional surcharge based on the number of days worked. However, an individual health care provider will not be required to pay more than the amount charged for the full-time annual PCF surcharge rate for the highest class used for locum tenens coverage for any 1 year period, commencing from the first date enrolled as a locum tenens.

F. **Nursing Home** applies only to a **licensed** "home" as defined in R.S. 40:2009.2. A nursing home may include both skilled nursing beds as well as other beds, in which case the number of each type of bed must be included on the application and the appropriate surcharge remitted. A *Skilled* nursing facility bed includes beds in which patients receive high intensive levels of care such as ventilator dependency and/or NRTP (closed head brain injury). *Intermediate* would be all other nursing home beds where daily care requires lower degree of semi-skilled care/supervision due to less severe illnesses or conditions. The PCF *Other* class has now been changed to ***Assisted living*** **only** and cannot be used for nursing home beds. Nursing home bed rates cannot be used for hospital beds. This rate can only be used when the facility is licensed as assisted living.

G. Corporate Coverage: The PCF provides coverage for legal corporations and partnerships based on information obtained from the Secretary of State's website showing that it is a registered legal entity. A trade name is not a corporation and will not be covered as such, but the PCF should be made aware that such exists and it should be included as a dba. The appropriate corporate designation is required – LLC, Inc, APMC, APDC, etc. For Corporate coverage, a certificate of insurance showing coverage for the corporation and PCF corporate application, PCF 9 on our website, is **required**. If self-insured, only the PCF corporate application is required. It must contain the names of **all** the providers eligible for enrollment (HCP specialties listed in our rate manual for which a PCF surcharge is owed) that make up the Corporation or Partnership, or are employees of the corporation or partnership. Coverage of employees must be verified by the PCF to determine if the corporation qualifies for coverage without any additional surcharge or if a surcharge is due in accordance with the statutes. Contract employees (MDs, NPs, CRNAs, etc) should also be listed and noted as such. No certificate of enrollment will be issued if there is a failure to comply with this provision. Coverage will not be established within this office or for any claim filed against a corporation that has not complied with these provisions by providing necessary information. **There is no corporate surcharge due for vicarious tail coverage if a PCF enrolled employee leaves the corporation and does not purchase PCF tail.**

H. Orthopedic Minor Surgery includes outpatient procedures such as toe surgery, arthroscopic procedures, closed reductions, percutaneous pinning and other percutaneous procedures. However, if general anesthesia is used for any of these procedures, Major Surgery classification is necessary.

I. Other Class: Those providers that are **not** specifically listed in the PCF rate manual should use the "other" classification. The PCF surcharge is 72% of the undiscounted underlying premium for $100,000/$300,000 coverage (although the provider may have higher limits) or $250 per FTE, whichever is greater. Contact the PCF if clarification is needed. If rating a FTE slot see *Full Time Equivalents "FTE"* which is letter "R". **This coverage excludes M.D.s, advanced practice nurses and any other class of provider specifically listed in this rate manual**. The amount of the underlying premium MUST be provided with the PCF surcharge and application or certificate of insurance. Failure to provide this information will delay issuance of a certificate of enrollment until the information is provided. Additional classifications and PCF specialty codes can be found on the website. First year discounts by primary insurers do not apply to the PCF rate calculations.

J. There is a $**250 minimum** charge that is a POLICY-WRITING MINIMUM for the PCF, and may not be pro-rated. Refunds will not be issued that do not allow for the minimum amount to be retained by the PCF.

K. The use of "**split maturity**" or "**blended rates**" for calculating the PCF surcharge **will not be allowed**. When an insured joins a policy mid-term, at the time of the annual PCF renewal, that insured's PCF surcharge cannot be calculated using two maturity levels. However, the PCF will allow an insured that begins a policy mid-term to remain 1st year claims made for the PCF if the initial time period was less ***than 8 months*** at the time of renewal. If the enrollment period was ***8 months or more,*** the insured must use 2nd year claims made for the PCF renewals.

L. Exclusions to coverage- PCF reserves the right to deny coverage for criminal acts, including but not limited to sexual abuse or molestation, battery or fraud and illegal abortions, whether committed by the insured or any person for whom the insured is

legally responsible. The PCF does not provide coverage for third party claims**.**

M. **Pharmacists** that are employed by a hospital or other institution in which prescriptions are not dispensed to non-patients, including those that have been discharged from the hospital, will not be required to pay a separate PCF surcharge. Any hospital that dispenses prescriptions to non-patients, including patients discharged from the hospital, employees or others, shall be required to pay a PCF surcharge. **The rate tables apply to all pharmacists.**

N. **Ambulance services** that are owned by a hospital must pay the appropriate PCF surcharge for EMTs, regardless of whether or not the service is provided exclusively for the hospital's patients or patients may be taken to other locations.

O. **Management companies** were added to the definition of health care providers and thus they are considered an eligible provider and must pay the appropriate PCF surcharge for enrollment. **The surcharge for each management company is $250.00.**

P. **Medical Directors** employed or working at a facility such as a hospital or nursing home may need individual coverage to be considered qualified. PCF surcharge section should be contacted to determine the surcharge amount. The determination will be based on patient contact, interaction and responsibility for decisions involving patient care.

Q. **Dentist or Orthodontist** who performs cosmetic injections, such as Botox and dermal fillers, must report such on their PCF application PCF 2 or PCF 6 and must use code 70002. The rates are the same as code 80002.

R. **Full Time Equivalents "FTE"** can be used; however the minimum charge is .25 of the classification of the providers or $250 whichever is greater. If specialty is classified as "other" the PCF surcharge will be 72% of the underlying premium for $100,000/$300,000 coverage or $250 per FTE, whichever is greater. One FTE is based on a 40 hour work week. A list of HCPs and the average hours they work per week will be needed to determine the correct surcharge. **Please note that the part time discounts cannot be applied to the Full Time Equivalency slot.**

S. **Retro Dates** for the PCF may not match the retro dates for the underlying carrier if primary coverage started prior to enrollment with the PCF. The PCF CM surcharge should be based on the year with the PCF in situations where the retro date for the primary is prior to enrollment with the PCF. **The PCF does not provide prior acts coverage for new enrollees.**

T. **Advanced Practice Nurses** must provide the name of the supervising or collaborating physician.

U. **Hospital ancillary staff**, such as RNs, LPNs, therapists, techs, pharmacists (see M), and other support staff and administrative staff are considered included in the PCF coverage by payment for the beds and outpatient visits. **This coverage excludes M.D.s, advanced practice nurses and any other class of provider specifically listed in this rate manual**.

V. **Accountable Care Organization** - An accountable care organization (ACO) is a health care entity that is responsible for the care of several thousand Medicare beneficiaries who are assigned to the ACO by the Centers for Medicare and Medicaid Services (CMS). The surcharge for each ACO will be 72% of the primary premium or $250, whichever is greater.

W. **Urgent Care Medicine** – There is now a specialty code for physicians practicing in Urgent Care facilities which is 80609 and is a Class 2A as well as an alternate rating for urgent care facilities (see letter I in the Supplemental Notes).

**** See list on PCF website for additional codes, classes & specialist if not found in this manual ****

III. PHYSICIANS, SURGEONS AND OTHER MEDICAL PROFESSIONALS CLASSIFICATIONS

	PCF Code	Class
Addictionology	80034*#	1
Administrative Medicine	80025	1A
Aerospace Medicine	80230*#	1A
Allergy	80254*#	1A
Anesthesiology (This classification applies to all general practitioners or specialists who perform general anesthesia or acupuncture anesthesia)	80151	3
Anesthetist	80004	RNA
Bariatric Medicine	80229	1
Bariatric Surgery	80180	6
Blood Center	80298	BC
Broncho-Esophagology	80101	3
Cardiovascular Disease – major invasive (This classification applies to any cardiologist performing any of the following procedures: Angiography, Intraluminal Angioplasty, Myelography)	80109	3
Cardiovascular Disease – no surgery	80255*#	2A
Cardiovascular Disease – minor surgery	80281*	3
Surgery – Cardiovascular Disease (major surgery)	80150	7
Chiropractor	80049	DCM
Clinical Nurse Specialist	80358	CNS
Dermatology – no surgery	80256*#	1A
Dermatology – minor surgery	80282*	1A
Diabetes - no surgery	80237*#	1
Diabetes - minor surgery	80271*	2
Emergency Medicine - no major surgery (This classification applies to any general practitioner or specialist regularly engaged in emergency practice at a clinic, hospital or rescue facility who does not perform major surgery	80102	4
******SEE NOTES FOR OPTIONAL PER PATIENT VISIT RATING BASIS******		
Emergency Medicine - including major surgery (This classification applies to any general practitioner or specialist regularly engaged in emergency practice at a clinic, hospital or rescue facility who performs major surgery)	80157	4
******SEE NOTES FOR OPTIONAL PER PATIENT VISIT RATING BASIS******		
Endocrinology - no surgery	80238*#	1
Surgery – Endocrinology (major surgery)	80103	5
Family Practice - no surgery	80239*#	2A
Family Practice - minor surgery	80273*	2
Forensic Medicine	80240*#	1A
Gastroenterology - no surgery	80241*#	1
Gastroenterology - minor surgery	80274*	2
Gastroenterology -major invasive procedures (This classification applies to any gastroenterologist performing colonoscopies, endoscopic retrograde cholangiopancreatographies and/or peritoneoscopies)	80535	3
Surgery – Gastroenterology (major surgery)	80104	5

General Practice - no surgery	80242*#	1
General Practice - minor surgery	80275*	2
General or Family Practitioner–major surgery (**NOT GENERAL SURGEON**)	80142	5
Surgery – General (This is an N.O.C. classification. This classification does apply to any general practitioner or specialist who occasionally performs major surgery)	80143	6
General Preventative Medicine - no surgery	80231*#	1A
Geriatrics - no surgery	80243*#	1A
Geriatrics – minor surgery (including institutional)	80276*#	2
Surgery – Geriatrics (major surgery)	80105	5
Gynecology - no surgery	80244*#	1A
Gynecology - minor surgery	80277*	2
Surgery – Gynecology (major surgery)	80167	5
Hematology - no surgery	80245*#	1
Hematology - minor surgery	80278*	2
Hospitalist	80330	2
Hypnosis	80232	1
Infectious Disease - no surgery	80246*#	2A
Infectious Disease - minor surgery	80279*	2
Intensive Care Medicine (This classification applies to any general practitioner or specialist employed in an intensive care hospital unit)	80339	3
Internal Medicine - no surgery	80257*#	2A
Internal Medicine - minor surgery	80284*	2
Laryngology - no surgery	80258*#	1
Laryngology - minor surgery	80285*	2
Surgery – Laryngology (major surgery)	80106	5
Licensed Midwives	80357	NM
Neonatology - intensive care medicine	80283	2
Neoplastic Dis./Oncology - no surgery	80259*#	1
Neoplastic Dis./Oncology - minor surgery	80286*	2
Surgery – Neoplastic (major surgery)	80107	5
Nephrology - no surgery	80260*#	1
Nephrology - minor surgery	80287*	2
Surgery – Nephrology (major surgery)	80108	5
Neurology - including child-no surgery	80261*#	2A
Neurology - including child-minor surgery	80288*	2
Surgery – Neurology – including children (major surgery)	80152	8
Nuclear Medicine	80262*#	1
Nurse Midwives	80357	NM
Nurse Practitioner	80324	NP
Nutrition	80248*#	1
Occupational Medicine	80233*#	1A
Ophthalmology - no surgery	80263*#	1A
Ophthalmology - minor surgery	80289*	2
Surgery – Ophthalmology (major surgery)	80114	2
Optometrists	80027	OD
Surgery – Optometry	80116	ODS

Orthopedic – no surgery/procedures	80401	1
Orthopedic – Minor surgery/procedures	80402	3
Surgery – Orthopedic (major surgery)	80154	6
Surgery – Orthopedic – spinal surgery ("Spinal surgery" includes any open procedure on the spine, except myelograms, epidural steroid injections, and diagnostic procedures)	80172	8
Otology – no surgery	80264*#	1
Otology – minor surgery	80290*#	2
Surgery – Otology (This classification does not apply to general practitioners or specialists performing plastic surgery) **(major surgery)**	80158	5
Otorhinolaryngology - no surgery	80265*#	1A
Otorhinolaryngology - minor surgery	80291*	2
Surgery – Otorhinolaryngology (This classification does not apply to general practitioners or specialists performing plastic surgery) **(major surgery)**	80159	5
Pain Management – Specialist	80325	3
Pathology - no surgery (Coverage is included for pathological labs)	80266*#	1
Pathology - minor surgery (Coverage is included for pathological labs)	80292*	2
Pediatrics - no surgery	80267*#	1
Pediatrics - minor surgery	80293*	2
Pharmacists	80005	RPH
Pharmacology – clinical	80234*#	1A
Physiatry - (no surgery/ no pain management)	80235*#	1A
Physicians-no major surgery (This classification applies to all general practitioners or specialists except those performing major surgery, anesthesiology or acupuncture anesthesiology, who perform any of the following medical techniques or procedures: **Catheterization** - occasional insertion of pulmonary wedge, recording catheters or temporary pacemakers, and umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen. **Needle Biopsy** including lung, liver, kidney and prostate **Radiopaque Dye Injections** into blood vessels, lymphatics, sinus tracts and fistulae.) **(NOT APPLICABLE TO RADIOLOGISTS, CODE 80280*)**	80533	2
Physicians - no major surgery (This classification applies to all general practitioners or specialists except those performing major surgery, or acupuncture anesthesiology, who perform any of the following procedures: **Acupuncture** - other than acupuncture anesthesia **Catheterization** - arterial, cardiac, central venous, or diagnostic, intraluminal angioplasty **Cryosurgery** - other than use on benign or pre-malignant dermatological lesions **Lasers** - used in therapy **Shock therapy** **Skin flaps** with arterial blood supply other than cancer therapy **Epidural injections** - for pain management	80534	3
Physicians - N.O.C. (No procedures)	80236	1A
Physicians - no surgery (This is an N.O.C. classification)	80268*	1
Physicians - minor surgery (This is an N.O.C. classification)	80294*	2
Physicians Assistant	80310	PAS

Podiatry	80003	2
Psychiatry - including children	80249*#	1A
Psychoanalysis	80250#	1
Psychosomatic Medicine	80251*#	1
Pulmonary Disease - no surgery	80269*#	1
Radiology-diagnostic-no surgery (Coverage is included for X-Ray Labs)	80253*#	2A
Radiology -diagnostic - minor surgery (Including radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae. Coverage is included for X-Ray Laboratories)	80280*#	2
Radiology - **major invasive procedures** (This classification applies to any radiologist performing angiographies, arteriographies, discograms, lymphangiographies, myelographies, phlebographies, pnuemoencephalographies, and /or radiation therapy)	80536	3
Rheumotology - no surgery	80252*#	1
Rhinology - no surgery	80247*#	1
Rhinology - minor surgery	80270*	2
Surgery – Rhinology (major surgery)	80160	5
Sleep Medicine	80608	2A
Sports Medicine – no surgery	80205	1
Sports Medicine – minor surgery	80204	3
Surgeon's Assistants	80323	SA
Surgery – Abdominal	80166	5
Surgery – Bariatric	80180	6
Surgery – Cardiac	80141	7
Surgery – Cardiovascular disease	80150	7
Surgery – Colon and rectal	80115	3
Surgery – Endocrinology	80103	5
Surgery – Gastroenterology	80104	5
Surgery – General (This is an N.O.C. classification. This classification does apply to any general practitioner or specialist who occasionally performs major surgery)	80143	6
Surgery – Geriatrics	80105	5
Surgery – Gynecology	80167	5
Surgery – Hand	80169	3
Surgery – Head and neck	80170	7
Surgery – Laryngology	80106	5
Surgery – Neoplastic	80107	5
Surgery – Nephrology	80108	5
Surgery – Neurology – including children	80152	8
Surgery – Obstetrics	80168	7
Surgery – Obstetrics/Gynecology	80153	7
Surgery – Ophthalmology	80114	2
Surgery - Optometry	80116	ODS
Surgery – Orthopedic	80154	6
Surgery – Orthopedic – spinal surgery ("Spinal surgery" includes any open procedure on the spine, except myelograms, epidural steroid injections, and diagnostic procedures)	80172	8

Surgery – Otology (This classification does not apply to general practitioners or specialists performing plastic surgery)	80158	5
Surgery – Otorhinolaryngology (This classification does not apply to general practitioners or specialists performing plastic surgery)	80159	5
Surgery – Plastic (This is an N.O.C. classification)	80156	5
Surgery – Plastic – Otorhinolaryngology	80155	5
Surgery – Rhinology	80160	5
Surgery – Thoracic	80144	6
Surgery – Traumatic	80171	6
Surgery – Urological	80145	3
Surgery – Vascular	80146	6
Urgent Care Medicine	80609*#	2A
Urology/Gynecology	80181	5
Wound Care Medicine	80610*#	1

III. SUPPLEMENTAL NOTES AND CHARGES

A. The following additional charges shall apply for ALL indicated classifications, including such practitioners employed by others and must be paid in addition to surcharges applicable for employing provider.

Locum Tenen Physician ***(Use specialty code of work being performed)***		**Class/specialty prorated for period worked (minimum $250)**
Home Health	80100	72% of primary/$250 min
Hospice	80499	72% of primary/$250 min
Management Companies	80326	$250
Accountable Care Organization	80327	72% of primary/$250 min
Psychologists	80047	72% of primary/$250 min
Ambulance Service	80014	.015 x PH1 rate x FTEs (Paramedics, EMTs, Nurses) $10 per EMT student

"Other" class percentage is based on undiscounted primary premium for $100,000/$300,000 coverage or $250 per FTE, whichever is greater. A list of HCPs and the average hours they work per week will be needed to determine the correct surcharge.

Corporate Liability	80313	20% of each individual class rate (**)
Partnership Liability	80314	20% of each individual class rate (**)

** No surcharge will be owed to the PCF to cover such entity if all shareholders/partners and professional employees, including contract employees, are enrolled and qualified with the PCF. Otherwise a charge of 20% of each class rate will be made for any eligible shareholders/partners and employee not enrolled in the PCF (this will only cover the corporation, not the non-enrolled individuals). This does not apply to corporate tail coverage in the event an employee leaves the corporation and does not purchase tail. ***A separate Certificate of Insurance showing the corporation as an insured and the PCF corporate application*** that lists all employed health care providers ***is required***. Regular nursing staff and other ancillary staff do not have to be listed if not listed in this rate manual and not the sole type of employees. Lists can be attached in lieu of inserting names on the form. Any questions should be directed to the PCF surcharge department.

B. **DROP DOWN CHARGE:** A physician or surgeon reducing classification will pay a ***one-time*** additional surcharge equal to the difference between the "tail" (reporting endorsement) charge for the higher classification and the tail charge for the lower classification. It will be based on the provider's maturity year at the time of the change. This additional surcharge may be waived if the provider has 10 or more consecutive years with the PCF. **This charge cannot be waived at the same time a Part-time discount charge is being waived.**

C. PART-TIME DISCOUNTS: A health care provider who is employed full-time by a hospital or clinic which has paid a full surcharge for his classification, and the health care provider is also in private practice OR a health care provider practicing on a part-time basis, may be eligible for a rate credit on the surcharge for his private practice, as follows:

35 hrs. practice/month or less	75% Credit
65 hrs. practice/month or less	50% Credit
85 hrs. practice/month or less	25% Credit
More than 85 hrs./month	No Credit

**** Based on 40 Hr work week***

***additional form required – see applications – PCF 12.**

*******Please note that the part time discounts cannot be applied to the Full Time Equivalency slot.*******

PART-TIME REDUCTION CHARGE: There will be a ***one-time*** additional surcharge for a health care provider with Claims Made coverage that is going from full-time to part-time practice. The charge will be based on the PCF tail surcharge for the provider's class less the full time renewal rate for that class. This amount will be added to the part-time renewal amount. This additional surcharge may be waived if the provider has 10 or more consecutive years with the PCF. **This charge cannot be waived at the same time a drop down charge is being waived.**

As an example, a provider going from full-time Class 1 to part-time with a 50% credit using the rates effective 9/2/10 would pay the following:

Class 1 Tail	$8,571.00	*cannot be pro-rated/discounted
Renewal	6,487.00	*cannot be pro-rated/discounted
Difference	$2,084.00	
50% Discount	3,243.00	*can be pro-rated for length of policy
Total PCF Surcharge	$5,327.00	

D. A physician or surgeon with a rate class in their primary insurance company that is different from the rate class shown in these pages for the Patients' Compensation Fund will in all instances pay the surcharge based on the PCF rate classes.

E. Intern and Resident Rating Procedures:

PCF Rate class applicable to specialty

Interns:	33% of indicated surcharge for applicable class
Residents:	66% of indicated surcharge for applicable class

F. Retiring, Deceased or Disabled Healthcare Provider: "Tail" coverage (Extended Reporting Endorsement) surcharges for these classes shall be considered as "included" in their last surcharge payment and no additional charge shall be required for this coverage if they have been in the PCF for **10 consecutive years**. However, a disabled health care provider or retired health care provider who subsequently returns to practice must pay all applicable surcharges, just as any other active physician. This waiver also applies to the "step down" charge used for physicians who reduce their PCF classification, if such reduction is the result of a permanent disability or illness which

allows the provider to continue to practice medicine, but requires a reduction in the specialty class (for example, dropping to a "no surgery" classification after previously qualifying as a surgeon or surgical assistant), the "step down" charge shall be considered "included" in the last surcharge paid at the higher classification. Please note that both the drop down charge and part time reduction charge cannot be waived at the same time. ***Retired is defined as no longer practicing medicine. Practicing medicine includes part time practice, volunteer work, practicing medicine in another state, and practicing and/or teaching for the State of Louisiana that requires patient contact.***

G. Non listed classes – classes/specialties which do not fall within the range of providers listed on these pages or in the complete list on the PCF website shall be rated at the discretion of the Fund. In most cases, such rates will follow the Insurance Service Office procedures.

H. ALTERNATE EMERGENCY PHYSICIAN RATING BASIS:

This rating basis is an option available to any group or individual Emergency Medicine practice whose underlying coverage is rated on a "per patient visit" basis (or, for self-insureds, those whose hospital contracts are maintained on a "per patient visit" basis). To qualify for this basis, providers must be able to supply the Fund with the means of verifying the number of patient visits recorded at year end. Such verification can take the form of premium audits from underlying policies, copies of verifications for hospital contracts, or any other form of verification acceptable to the Fund. Surcharges paid to the Fund will be adjusted at the end of each policy year based on verified numbers submitted. (PLEASE NOTE: This rating basis is the only alternative available to rating Emergency Medicine on a per-physician basis. Under no circumstances will any ER group or practice be rated as per the "All Other" rating procedures.)

Rates per patient visit are as follows:

CLASS	CLAIMS MADE MATURITY YEAR					OCC/SI
Regular Coverage:						
	1	**2**	**3**	**4**	**5**	
4	1.07	1.79	2.10	2.27	2.39	2.59
"Tail" Coverage:						
4	1.91	2.72	3.02	3.15	3.15	

I. ALTERNATE URGENT CARE RATING BASIS:

This rating basis is an option available to any Urgent Care facility whose underlying coverage is rated on a "per patient visit" basis (or, for self-insureds, those whose hospital contracts are maintained on a "per patient visit" basis). To qualify for this basis, providers must be able to supply the Fund with the means of verifying the number of patient visits recorded at year end. Such verification can take the form of premium audits from underlying policies, copies of verifications for hospital contracts, or any other form of verification acceptable to the Fund. Surcharges paid to the Fund will be adjusted at the end of each policy year based on verified numbers submitted. (PLEASE NOTE: This rating basis is the only alternative available to rating Urgent Care Medicine on a per-provider basis. Under no circumstances will any Urgent Care group or practice be rated as per the "All Other" rating procedures.)

Rates per patient visit are as follows:

CLASS	CLAIMS MADE MATURITY YEAR					OCC/SI
Regular Coverage:						
	1	**2**	**3**	**4**	**5**	
Urgent Care	.42	.71	.82	.88	.93	1.01

"Tail" Coverage:						
Urgent Care	.74	1.06	1.18	1.23	1.23	

EXPERIENCE RATING

1. General:

Effective 7-1-93, the PCF initiated an experience-rating program. The intent of the plan is to apportion a greater percentage of needed increases to those providers who generated a greater-than-expected number of losses. This provision applies to all providers. The maximum increase for any provider is 50% of the annual surcharge.

While the provisions for application to the practitioner and hospital classes are slightly different, both operate under the following general parameters:

- Only those providers with two or more eligible losses in the five-year rating period, either paid or reserved, will be affected. Not every provider meeting the criteria for rating shall earn a debit: a number of providers whose total losses fall below the indicated thresholds will simply pay normal surcharges according to their classification.

  1. Any closed claim for which a loss payment was made with a report date of 5 years prior to the renewal date
  2. Any open reserved or paid loss, regardless of date filed
  3. Any claim with on-going medical expenses being paid, regardless of original report date, with only the expenses paid during the policy year being used in the calculation

- Losses used in the rating plan will be valued as of 90 days prior to the expiration of the provider's coverage. Any changes in loss value after that date will be included in the next year's evaluation.
- Most providers in the "Other" class will be experience rated under PH1. Some providers that are in the "Other" classification, such as institutions, entities or non-individual HCPs, will be experienced using the hospital/non-individual worksheet.
- The Fund (rather than the providers and primary carriers), will calculate all modifiers and send appropriate notice to the providers and carriers prior to renewal. Each affected provider will be given a copy of the worksheet used in the calculation, so that they may review the loss data for accuracy.
- Penalties are required in addition to the indicated surcharge increase shown in the attached rating pages.

2. Physician, APRN, DDS, Oral Surgeons, Chiropractors and Other Classes, (Individual HCPs) Experience Rating Specifics:

A. The individual provider class modifiers rely on specific ranges of losses. These vary by class. For physicians, it is the PH class number. For the remainder individual providers, the PH 1 class is used. Those eligible providers with total limited losses in the five-year period which fall within the stated ranges shown below will earn the indicated debit modifier.

B. Modifiers are to be applied to the indicated renewal surcharge. (For example, a provider paying $10,000 in normal surcharges who earns a 20% penalty will pay a total of $12,000—i.e., $10,000 x 1.20.)

C. The indicated modifier shall be re-evaluated at each subsequent renewal. It is anticipated that providers may be experience rated or not each year depending on the loss results at the time of each renewal.

D. The maximum penalty to any provider is 50% in a policy year.

E. Indicated modifiers and loss limitations by class:

PH1A, 1 APRN & OTHERS		PH2A & 2		PH3	
% Debit	LOSS RANGE	% Debit	LOSS RANGE	% Debit	LOSS RANGE
0	Up to $15,866	0	Up to $26,184	0	Up to $38,897
10	$15,867 to $47,049	10	$26,185 to $60,301	10	$38,898 to $83,993
20	$47,050 to $92,849	20	$60,302 to $118,115	20	$83,994 to $148,956
30	$92,850 to $153,010	30	$118,116 to $185,168	30	$148,957 to $224,299
40	$153,011 to $222,785	40	$185,169 to $273,491	40	$224,300 to $335,628
50	$222,786 or more	50	$273,492 or more	50	$335,629 or more

PH4		PH5		PH6	
0	Up to $47,598	0	Up to $57,284	0	Up to $71,227
10	$47,599 to $88,159	10	$57,285 to $108,547	10	$71,228 to $118,825
20	$88,160 to $156,893	20	$108,548 to $182,394	20	$118,826 to $199,484
30	$156,894 to $236,611	30	$182,395 to $279,669	30	$199,485 to $293,033
40	$236,612 to $341,618	40	$279,670 to $394,599	40	$293,034 to $416,258
50	$341,619 or more	50	$394,600 or more	50	$416,259 or more

PH7		PH8	
0	Up to $109,452	0	Up to $131,664
10	$109,453 to $178,112	10	$131,665 to $209,925
20	$178,113 to $277,021	20	$209,926 to $307,642
30	$277,022 to $423,171	30	$307,643 to $435,997
40	$412,172 to $599,077	40	$435,998 to $605,070
50	$599,078 or more	50	$605,071 or more

3. Hospitals, Nursing Homes, Centers Exp Rating Specifics

A. Institutional modifiers are individually calculated based upon the provider's 5-year loss ratio with the Fund: that is, the relationship of surcharges paid in to losses paid out and reserved within the same five-year period. The losses shall be subject to the limitations shown below. The indicated modifier shall be the debit (if any) indicated by the loss ratio (i.e., any portion over 100%), subject to the maximum penalty of 50%.

B. MAXIMUM SINGLE LOSS PROVISIONS: Those entities that have paid a cumulative total of less than $300,000 into the Fund in the past five policy years shall have each individual loss limited to $300,000 for experience rating. Those hospitals which have paid in a cumulative total of $300,000 or more over the past five policy years shall have each individual loss limited to $500,000 for experience rating.

C. No provider shall pay more than 50% in penalty.

D. As in the individual practitioner classes, losses shall be valued as of 90 days prior to renewal of coverage. Any changes in value after that date shall be considered in the following years' rating.

E. Each provider shall be supplied with a copy of their worksheet, so that they may review losses and surcharge records for accuracy.

F. In the event of a complete change of corporate ownership, the Fund may, at its discretion, amend the experience rating basis of the new entity to identify pending development of data by the new entity. Each such entity desiring such a change must make individual submission to the Fund. The new entities shall begin new experience ratings after completing one policy year under the new ownership.

G. Example of worksheet attached.

Revised 9/18/19

LA PATIENTS COMPENSATION FUND

EXPERIENCE RATING WORKSHEET

PHYSICIANS

INSURED:

PROV #: SPECIALTY/PCF PH CLASS:

RENEWAL EFFECTIVE DATE: LHA PHYSICIANS' TRUST

SUBJECT LOSSES:	RESERVE / PAYMENT	AMOUNT
	TOTAL (LTD)	**$**

Indicated Debt: **0%**

***MAXIMUM DEBIT PERCENTAGE 50%**

Losses subject to rating: 1. Any paid, closed loss originating within five calendar years of renewal date; AND
2. Any open loss valued at $2 or more (regardless of report year)

PH1A, 1 & OTHERS

% Debit	LOSS RANGE
0	Up to $15,866
10	$15,867 to $47,049
20	$47,050 to $92,849
30	$92,850 to $153,010
40	$153,011 to $222,785
50	$222,786 or more

PH2A & 2

% Debit	LOSS RANGE
0	Up to $26,184
10	$26,185 to $60,301
20	$60,302 to $118,115
30	$118,116 to $185,168
40	$185,169 to $273,491
50	$273,492 or more

PH3

% Debit	LOSS RANGE
0	Up to $38,897
10	$38,898 to $83,993
20	$83,994 to $148,956
30	$148,957 to $224,299
40	$224,300 to $335,628
50	$335,629 or more

PH4

0	Up to $47,598
10	$47,599 to $88,159
20	$88,160 to $156,893
30	$156,894 to $236,611
40	$236,612 to $341,618
50	$341,619 or more

PH5

0	Up to $57,284
10	$57,285 to $108,547
20	$108,548 to $182,394
30	$182,395 to $279,669
40	$279,670 to $394,599
50	$394,600 or more

PH6

0	Up to $71,227
10	$71,228 to $118,825
20	$118,826 to $199,484
30	$199,485 to $293,033
40	$293,034 to $416,258
50	$416,259 or more

PH7

0	Up to $109,452
10	$109,453 to $178,112
20	$178,113 to $277,021
30	$277,022 to $423,171
40	$412,172 to $599,077
50	$599,078 or more

PH8A & 8

0	Up to $131,664
10	$131,665 to $209,925
20	$209,926 to $307,642
30	$307,643 to $435,997
40	$435,998 to $605,070
50	$605,071 or more

SURCHARGE AMOUNT DUE: _____

EXPERIENCE RATING DUE: _____

TOTAL AMOUNT DUE: _____

LA PATIENTS COMPENSATION FUND

EXPERIENCE RATING WORKSHEET:

INSTITUTIONAL

(NOTE: ONLY THOSE PROVIDERS WITH TWO OR MORE LOSSES MEETING THE REQUIREMENTS SHOWN BELOW ARE SUBJECT TO THIS RATING PROGRAM)

INSURED NAME:

PROV. #: RENEWAL EFFECTIVE DATE:

SELF INSURED

SURCHARGES PAID		CLAIM	AMT OF PAYMENT OR RESERVE	PAYMENT OR RESERVE	AMOUNT CHARGED
1ST PREVIOUS					
2ND PREVIOUS					
3RD PREVIOUS					
4TH PREVIOUS					
5TH PREVIOUS					
TOTAL*	**$**		TOTAL (LTD)		**$**

***IF TOTAL SURCHARGES ARE $300,000 OR LESS, INDIVIDUAL LOSSES SHALL BE LIMITED TO $250,000 EACH FOR EXPERIENCE RATING. IF TOTAL SURCHARGES ARE $300,001 OR MORE, INDIVIDUAL LOSSES SHALL BE LIMITED TO $500,000 EACH FOR EXPERIENCE RATING PURPOSES.**

****LIMIT LOSSES INDIVIDUALLY AS INDICATED BY SURCHARGE TOTALS**

LOSS RATIO = LIMITED LOSSES/SURCHARGES

LOSSES = **$** LOSS RATIO =

SURCHARGE = **$**

EXPERIENCE DEBIT = LOSS RATIO MINUS 1.00***

TOTAL INDICATED DEBIT: **0%**

PCF SURCHARGE DUE = RENEWAL RATE X 1.__

*****MAXIMUM DEBIT PERCENTAGE 50%**

Losses subject to rating:

1. **Any paid, closed loss originating with five calendar years of renewal date; AND**
2. **Any open loss valued at $2 or more (regardless of report year)**