Louisiana Department of Health and Hospitals
Health Plan Advisory 15-11
Revised Aug. 19, 2015

Issue: Transition of Retroactive Reimbursement Functions

Beginning Feb. 1, 2015, Managed Care Organizations (MCOs) are responsible for direct reimbursement to a Medicaid eligible recipient (member) for their payment(s) made to any Medicaid-enrolled provider for medical care, services and supplies delivered during the recipient's period of retroactive eligibility and prior to the expected date of receipt of the MCOs ID card and/or expected date of receipt of notification of linkage to the MCO. Value added services offered by the MCOs are not eligible for reimbursement.

MCOs must have written policies and procedures for receiving, processing and issuing payment for recipient (member) reimbursement requests and some type of tracking system that can be accessed by their Member Services staff.

MCOs shall provide customer service to members who seek explanations and/or education regarding retroactive reimbursement issues.

MCOs are required to use claims payment business processes that deny or approve requests for retroactive reimbursement. For approved requests, the business processes must be able to do the following: edit, adjudicate, adjust, void, pay and audit request for reimbursement of covered Medicaid services. In cases of a retroactive payment involving other insurance, the MCO may instruct the provider to resubmit the unpaid portion of the claim(s) to the MCO for payment (if applicable).

MCOs must provide written notice of eligibility for retroactive reimbursement information in a member welcome letter. Changes to existing documents must be reviewed and approved by DHH in advance.

- A member's intent to make a request for reimbursement must be made known to the MCO within 30 calendar days from the date of the welcome letter.
    - If an extension is requested on or before the deadline, an additional 10 days shall be given.
    - If a second extension is requested before the deadline of the first extension, no more than 10 additional days should be granted.

- Additional information requested from the member by the MCO should be submitted within 15 days from the date of the request.
    - If the member requests an extension on or before the deadline, it shall be provided, not to exceed 30 days.
    - If the recipient fails to submit the requested verification in the allotted time, the request for reimbursement should be processed as denied.
    - If the additional documentation is received, the MCO must follow the established timeframes as stated in Section 17 (Claims Processing) of the MCO contract.

Reimbursement shall be provided only under the following conditions:

- Reimbursement shall be made only for payments made to providers of medical care, services and supplies who were enrolled in the Medicaid Program at the time of service.
- The medical care, services and supplies were covered by the Medicaid Program at the time of service.
- The medical care, services and supplies were delivered during a retroactive eligibility period.
- Reimbursement shall be made at the Medicaid rate (regardless of whether the provider is a participating or non-participating provider) for the particular service(s) rendered.
- The member has not received reimbursement from Medicaid, the Medicaid provider, nor received payment in full by a third party entity.
- If durable medical equipment (DME); dates of service, quantity, diagnosis and procedure codes, documentation of medical necessity from the doctor, amount billed, amount member paid and verification of private insurance payments (EOB).

The member must provide proof of payment to the MCO. Bills which were paid in full by a third party (such as an insurance company, charitable organization, family or friend) cannot be considered for reimbursement unless the member remains liable to the third party. It is required that continuing liability of the member be verified.

Payment Methodology for Reimbursements Involving Third-Party Liability (TPL)

A cost comparison method should be used for recipient reimbursement request involving TPL. The claim must first be processed by the primary payor. The TPL payment amount will be applied just as the primary payor indicates on the EOB. The reimbursement to the member shall be the Medicaid allowed amount minus the TPL payment. If the TPL payment is more than the Medicaid allowed amount, the reimbursement to the member would be zero.

DHH's process requires that members must submit a copy of the bill(s) or other acceptable verification which includes all of the following:

- Name of the member who received the service,
- Name, address and phone number of the physician or facility providing the service,

- Date of service,
- Procedure and diagnosis codes,
- Receipt(s) or other acceptable proof showing that the bill was paid by the member or someone else,
- Amount of billed charges and verification of payment, and
- Proof of payment by any Private Insurance – explanation of benefits (EOB),

And, if applicable:

- If durable medical equipment (DME); dates of service, quantity, diagnosis and procedure codes, documentation of medical necessity from the doctor, amount billed, amount member paid, and verification of private insurance payments (EOB).
- If pharmacy – date prescription was filled, National Drug Code (NDC), quantity dispensed, and retail cash price if insurance or discount card was used or the amount paid by the third party entity.
- If dental – diagnosis and procedure codes per tooth (not applicable as this is currently a carved out service for MCOs).

Bills Not Eligible for Reimbursement

- Unpaid bills – The MCO should instruct the member to present their MCO ID card to the provider for billing purposes.
- Bills paid by the recipient after receipt of the initial MCO ID card.
- Bills paid to a non-Medicaid provider who does not participate in the Medicaid Program.
- DME purchased without documentation of medical necessity
- Over the counter medications or supplies purchased without a prescription.
- Value added services offered by the MCO.

All notices of action, decisions, approvals or denials, must be sent to the member in writing, using language that is easily understood by the member and must include Appeal rights.

Processing Timeframes

- MCOs must follow established timeframes as stated in Section 17 (Claims Processing) of the MCO contract. A reimbursement request is considered clean when the member has timely submitted all requested documentation within the established timeframe.
- Requests received for reimbursement of payment for carved-out services must be uploaded to DHH's SharePoint website within five business days of receipt, for processing by DHH.

Reporting

Encounter data is not required at the present time for member reimbursements; however ad hoc reporting may be requested at a later date.

Encounter data is required for provider reimbursements only, such as when the member has partially paid and the MCO instructs the provider to submit the unpaid portion of a claim to the MCO for payment.