POLICY AND PROCEDURE

POLICY NAME: Retroactive Reimbursement	**POLICY ID:** LA.MBRS.21
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA:** Customer Service / Member Advocates
EFFECTIVE DATE: 04/2015	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 5/16, 4/17, 4/18, 4/19, 2/20, 10/20, 11/21, 8/22, 7/23, 5/24, 3/25, 12/25	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
This policy outlines retroactive reimbursement for Medicaid enrollees.

PURPOSE:
To provide guidance for the handling of requests from Louisiana Medicaid members for retroactive reimbursement.

SCOPE:
Louisiana Healthcare Connections (LHCC) Customer Service.

DEFINITIONS:
LDH = Louisiana Department of Health

POLICY:
Louisiana Healthcare Connections is responsible for processing retroactive reimbursement requests submitted by Medicaid enrollees. Medicaid enrollees may be directly reimbursed for part or all of any medical expenses paid by them to any Medicaid provider for medical care, services, and supplies delivered during the period of retroactive eligibility and prior to the expected date of receipt of LHCC's ID Card and/or expected date of receipt of notification of linkage to LHCC. Value-added benefits offered by LHCC are not eligible for reimbursement.

~~**PROCEDURE:**~~
LHCC ~~shall~~ provides customer service to members who seek explanations and/or education regarding retroactive reimbursement issues.

LHCC ~~is required to~~ uses 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 requests for reimbursement of covered Medicaid services. In cases of a retroactive payment involving third party liability, LHCC may instruct the provider to resubmit the unpaid portion of the claim(s) for payment (if applicable).[JL1]

LHCC ~~must~~ provides written notice of eligibility for retroactive reimbursement information in an enrollee welcome letter. The welcome letter ~~must~~ includes the following policies and ~~provide~~provides the date the request is due:

- Enrollees are eligible for reimbursement of medical expenses paid three months prior to the month of application if they requested retroactive coverage on their application and received approval.
- Enrollees are given 30 calendar days from the date of the welcome letter to contact LHCC to request consideration for reimbursement and provide the required documentation.
- An extension of up to 10 calendar days shall be granted if the extension is requested on or before the deadline. A second extension of no more than 10 additional calendar days should be granted if the extension is requested before the deadline of the first extension. No extensions shall be granted beyond this timeframe.[JL2]

Changes to existing documents (e.g., policies, welcome letter templates) must be reviewed and approved by ~~Louisiana Department of Health (~~LDH~~)~~ in advance.

Reimbursement Criteria
Reimbursement shall be provided only under the following conditions:

- The enrollee is Medicaid eligible for the date of service.
- LHCC has verified that the provider is enrolled with LHCC on the date on which the enrollee received the service and is approved to provide the service rendered.

- The bills must be for services received on or after the Medicaid effective date through receipt of the initial Medicaid eligibility card (MEC) or reactivation of the MEC. Reactivation of the MEC would take place when an enrollee of Medicaid status has an interruption in coverage, reapplies and is certified for coverage in a qualifying Medicaid program. The certification period is usually twelve months.
- The medical bills must be for medical care, services, or supplies covered by Medicaid at the time the service was delivered.
- The enrollee has not received reimbursement from Medicaid or the Medicaid provider or received payment in full by a third-party entity.
- The enrollee must provide proof of payment to LHCC. Bills which were paid in full by a third party (e.g., Medicare, an insurance company, charitable organization, family, or friend) cannot be considered for reimbursement unless the member remains liable to the third party. It is a requirement that continuing liability of the enrollee be verified.

Bills Not Eligible for Reimbursement

- Unpaid bills - the enrollee should present his or her Medicaid eligibility card (MEC) to the provider along with the unpaid bill so that the provider can file a claim.
- Bills paid by the enrollee after receipt of the initial MEC or reactivation of the MEC.
- 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 benefits offered by LHCC.

Reimbursements Involving Third Party Liability

LHCC ~~should~~ uses a cost comparison method for enrollee reimbursement requests involving third-party liability (TPL). The claim must first be processed by the primary payer. The TPL payment amount is provided on the explanation of benefits (EOB) sent by the primary payer. The reimbursement to the enrollee shall be the Medicaid allowed amount minus the TPL payment. If the TPL payment is greater than the Medicaid allowed amount, the reimbursement to the enrollee would be zero.[JL3]

LHCC ~~shall~~ requires enrollees to submit all of the required documentation listed below within the timeframes specified above.

Required Documentation

An enrollee seeking reimbursement must provide to LHCC a copy of the bill(s) or other acceptable verification which include(s) the following:

- Name of the individual who received the service,
- Name, address and phone number of the physician or facility providing the service,
- Date of service,
- Procedure and diagnosis codes,
- Amount of billed charges and verification of payment
- Receipts or other acceptable proof showing that the bill was paid by the Medicaid enrollee or someone else. If paid by someone else, proof that the eligible is still liable for repayment to the individual who paid the bill
- 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 provider, amount billed, amount enrollee paid, and verification of private insurance payments (EOB).
- If dental – diagnosis and procedure codes per tooth.
- 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 LHCC determines that additional information is needed from the enrollee, LHCC ~~shall~~ will mail a Recipient Verification Request Form to the enrollee within three business days of the receipt of the initial request.

The enrollee ~~shall be~~is allowed 15 days to provide the additional documentation and, upon request for additional time, be granted an extension. If an extension is requested, no more than 15 additional days shall be granted. Enrollees who fail to provide the requested documentation or fail to request an extension shall have the request for reimbursement denied.

Processing Timeframes
LHCC follows established timeframes as required by the Contract. A reimbursement request is considered clean when the enrollee has timely submitted all requested documentation within the established timeframe; therefore, LHCC will process the request within three months from the date of the request and mail a Notice of Decision Letter to the enrollee. If the request is denied, the notice includes a clear explanation of the reason(s) for ineligibility for reimbursement.
Requests received by LHCC for reimbursement of payment for carved-out services will be submitted to LDH within five business days of receipt for processing by LDH.

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

Tracking and Reporting

- All requests for retroactive reimbursement are tracked using the Retro Reimbursement Tracking database.
- This database is easily accessible by member services and allows for reporting on the status of all retroactive reimbursement requests received.

~~**Bills Not Eligible for Reimbursement**~~

- ~~Unpaid bills - the enrollee should present his or her Medicaid eligibility card (MEC) to the provider along with the unpaid bill so that the provider can file a claim.~~
- ~~Bills paid by the enrollee after receipt of the initial MEC or reactivation of the MEC.~~
- ~~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 benefits offered by LHCC.~~

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REFERENCES:
~~LDH~~ Louisina Medicaid Managed Care Organization (MCO) Manual – Enrollee Retroactive Reimbursement

ATTACHMENTS:
See work process titled, “MA Retro Reimbursement Process”. Work process is located on LHCC Support Services - Home SharePoint site.

ROLES & RESPONSIBILITIES:
LHCC - Member Advocates
LHCC – Marketing
LHCC – Claims

REGULATORY REPORTING REQUIREMENTS:
La R.S. 46:460.54 applies to material changes to this policy.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy Document	New Policy from DHP Adv 15-1	05/27/15

Annual Review	No revisions	05/24/16
Annual Review	Changed DHH to LDH	04/24/17
Annual Review	Reviewed with no changes	04/24/18
Annual Review	Reviewed with no changes	04/25/19
Ad Hoc Review	Removed the word “to” from the purpose statement.	02/25/20
Annual Review	No Revisions	10/26/20
Annual Review	No Revisions	11/19/21
Annual Review	Added Tracking and Reporting section Updated all Bills Not Eligible for Reimbursement section Added Processing Time Frames Section Added reference to LDH MCO Manual – Enrollee Retroactive Reimbursement Updated policy section to align with language in the MCO Manual Updated procedure section to align with the language in the MCO Manual. Added in three bullets to clarify welcome letter expectations Updated all reimbursement criteria to align with the MCO Manual Added language related to Reimbursements Involving Third Party Liability Updated all required documentation section to align with the MCO manual	08/30/22
Annual Review	Reformatted to latest policy template Added the Policy Statement Updated Reimbursement Criteria with language from the MCO Manual Removed the HPA reference Grammatical Updates	07/11/23
Annual Review	No Revision	05/14/24
Annual Review	No Revision	03/11/25
Annual Review	Changed language from shall to what LHCC does where applicable Rearranged sections to align with MCO manual Minor grammar changes were made Removed section label of “Procedure” as this is a policy only document and does not contain any work procedure details. Added reference to MA Retro Reimbursement Work Process	12/19/25

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company’s P&P management software, is considered equivalent to a signature.