POLICY AND PROCEDURE

POLICY NAME: Claims Management – Claims Processing	**POLICY ID:** LA.CLMS.03
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA:** Claims Operations
EFFECTIVE DATE: 07/15	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 06/16, 6/17, 6/18, 6/19, 7/20, 3/21, 6/21, 6/22, 32/23	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
The document outlines the Plan's guidelines for claims processing.

PURPOSE:
The purpose of this policy is to clearly define the PLAN guidelines for claims processing.

SCOPE:
Louisiana Healthcare Connections (Plan) Claims operations.

DEFINITIONS:
n/a

POLICY:
Claims Processing
The PLAN will ensure that all provider claims are processed according to the following timeframes: (2.18.2)

- Within five (5) business days of receipt of a claim, the PLAN will perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.
- Process and pay or deny, as appropriate, at least Ninety percent (90%) of all clean claims for each claim type, within fifteen (15) calendar~~business~~ days of the receipt.
- Process and pay or deny, as appropriate, at least One Hundred percent (100%) of all clean claims for each claim type, within thirty (30) calendar days of the date of receipt.
- Fully adjudicate (pay or deny) all pended claims within sixty (60) calendar days of the date of receipt.

The PLAN shall ensure that all provider claims are processed appropriately in accordance with this contract and the System Companion Guide.

- Not automatically adjust, down-code, or pay claims at a lower level of service than what was submitted by the provider.
- In accordance with 42 CFR § 455.440, all claims for payment for items and services that were ordered or referred shall contain the National Provider Identifier (NPI) of the provider who ordered or referred such items or services.
- ~~[redacted]~~

PROCEDURE:
Rejected Claims (2.18.3)
The PLAN may reject claims because of missing or incomplete information. Paper claims that are received by the PLAN that are screened and rejected prior to scanning must be returned to the provider with a letter notifying them of the rejection. Paper claims received by the PLAN that are scanned prior to screening and then rejected, are not required to accompany the rejection letter.

A rejected claim should not appear on the Remittance Advice (RA) because it will not have entered the claims processing system, (except for pharmacy RA's). ~~.~~ The rejection letter will indicate why the claim is being returned, including all defects or reasons known at the time the determination is made and at a minimum, must include the following:

- The date the letter was generated;
- The patient or member name;

- Provider identification, if available, such as provider ID number, TIN or NPI;
- The date of each service;
- The patient account number assigned by the provider;
- The total billed charges;
- The date the claim was received; and
- The reasons for rejection.

Pended Claims (2.18.4)
If a clean claim is received, but additional information is required for adjudication, the PLAN may pend the claim and request in writing (notification via e-mail, Web site/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all necessary information such that the claim can be adjudicated within established timeframes.

Claims Reprocessing (2.18.6)
If the PLAN or LDH or its subcontractors discover errors made by the PLAN when a claim was adjudicated, the PLAN will make corrections and reprocess the claim within fifteen (15) ~~thirty (30)~~ calendar days of discovery, or notification or if circumstances exist that prevent the PLAN from meeting this time frame, a specified date will be approved by LDH. The PLAN will pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond either the fifteen (15) ~~thirty (30)~~calendar day claims reprocessing deadline or the specified deadline approved by LDH, whichever is later.
The PLAN will automatically recycle all impacted claims for all providers and will not require the provider to resubmit the impacted claims.

Timely Filing Guidelines (2.18.8)
Medicaid-only claims must be filed within three hundred sixty-five (365) calendar days of the date of service. Electronic submission of pharmacy claims (reversals and resubmittals) will be allowed to process electronically within three hundred sixty-five (365) days of service.

Claims involving third party liability will be submitted within 365 calendar days from the date of service. Medicare claims will be submitted within six (6) months of Medicare adjudication.

When Medicare is the primary insurer, the PLAN shall require network providers to file the claim within one hundred eight (180) calendar days from Medicare's EOB of payment or denial. (2.18.8.4)

The PLAN must deny any claim not initially submitted to the PLAN by the three hundred and sixty-fifth (365) calendar day from the date of service, unless LDH, the PLAN or its sub-contractors created the error. The PLAN will not deny claims solely for failure to meet timely filing guidelines due to error by LDH or its subcontractors.

For purposes of PLAN reporting on payment to providers, an adjustment to a paid claim will not be counted as a claim and electronic claims will be treated as identical to paper based claims.

The PLAN shall comply with all Federal and State laws, regulation, rules, policies, procedures, and manuals, the State plan, and applicable Waivers governing direct reimbursement to Enrollees for payments made by them for MCO Covered Services and supplies delivered during a period of retroactive eligibility. (2.3.12.1.4)

The PLAN will not deny claims submitted in cases of retroactive eligibility for timely filing if the claim is submitted within one hundred and eighty (180) calendar days from the member's linkage to the PLAN. The exception to the retroactive eligibility timely filing requirements are such that the claim must be submitted to the PLAN by the latter of the three hundred and sixty-fifth (365) calendar day from the date of service or one hundred and eighty (180) calendar days from the member's linkage to the PLAN.

Claim System Edits (2.18.9)
The PLAN will perform system edits, including, but not limited to:

- Confirming eligibility on each member;
- Validating member name;
- Validating unique member identification number;

- Validating date of service - Perform system edits for valid dates of service, and assure that dates of services are valid dates such as not in the future or outside of a member's Medicaid eligibility span;

- Determination of medical necessity - by a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity;

- Prior Approval – The system will determine whether a covered service required prior authorization and if so, whether the PLAN granted such approval;

- Duplicate Claims – The system will in an automated manner, flag a claim as being exactly the same as a previously submitted claim or a possible duplicate and either deny or pend the claim as needed;

- Covered Services - Ensure that the system verifies that a service is a covered service and is eligible for payment;

- Provider Validation - Ensure that the system will approve for payment only those claims received from providers eligible to render service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in ~~Section 9.4~~the *Provider Network, Contracts, and Related Responsibilities* section; and

- Quantity of Service - Ensure that the System will evaluate claims for services provided to members to ensure that any applicable benefit limits are applied.

- Perform post-payment review on a sample of claims to ensure services provided were medically necessary.

The PLAN will have the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CMS, and move to future versions as required by CMS or LDH. Updates to code sets are to be complete no later than 30 calendar days after notification, unless otherwise directed by LDH. This includes annual and other fee schedule updates.

Providers must be notified as to when the updates will be in production and of the PLAN process for the recycling of denied claims that are due to the system update delays. The recycle of these denied claims will be complete no later than 15 calendar days after the system update.

The PLAN will use only national standard code sets such as CPT/HCPS, ICD-10-CMS, etc. (unless it conflicts with LDH policy or state regulations). The PLAN will also comply with deadlines for communication, testing and implementation of code sets established by CMS and/or LDH.

In addition to CPT, ICD-9-CM, ICD-10-CM, ICD-10-PCS and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the PLAN and LDH to evaluate performance measures.

The PLAN will perform internal audit reviews to confirm claim edits are functioning properly and provide LDH with confirmation of this process. LDH will be provided the results of internal audit reviews upon request.

The PLAN will employ CMS mandated edits for Medicaid and nationally recognized clinical editing standards as outlined below:

- At a minimum, these edits will be maintained and updated annually unless otherwise appropriate and apply to practitioners, outpatient hospitals, and DME services.
- Edits will be based on current industry benchmarks and best practices including, but not limited to, specialty society criteria, American Medical Association CPT coding guidelines, and CMS mandated edits for Medicaid, which include the quarterly National Correct Coding Initiative (NCCI) edits or its successors.
- Clinical edits include, but are not limited to, units of service, unbundling, mutually exclusive and incidental procedures, pre/post-op surgical periods, modifier usage, multiple surgery reduction, add-on codes, cosmetic, and assistant surgeon. Editing will include the ability to apply edits to the current claim as well as paid history claims when applicable.
- NCCI edits will be updated quarterly as directed by CMS and adhere to CMS/LDH timelines.
- The PLAN will apply edits for physician-administered drugs, updated quarterly, based on the CMS NDC-HCPCS Crosswalk file.

- The PLAN will attest annually, or as otherwise directed, that they are adhering to these requirements and are subject to periodic requests from LDH for validation of the edits.

REFERENCES:
LDH Model Contract sections 2.18.2, 2.18.3, 2.18.4, 2.18.6, 2.18.8, 2.18.8.4, 2.18.9~~PLAN-2020 Louisiana Medicaid PLAN Emergency Contract – Sections, 17.2.1 – 17.2.7~~

ATTACHMENTS:

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:
~~Which regulator(s) require reporting, what should be reported, when to report, and how to report/who to contact.~~HB 434, Act 319 applies to material changes of this policy.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Added "Timely Resolution and Interest Payments to the DOCUMENT NAME Added "timely resolution of claims and interest payments to the PURPOSE Changed "Timely Claims Payment" to "Timely Resolution of Claims" Added 9.5.4 to REFERENCE list	6/16
Annual Review	No revisions	6/17
Annual Review	Added claim processing time specific to the RFP and adjusted the references section to the correct RFP sections	6/18
Annual Review	No revisions	6/19
Annual Review	No revisions	6/20
Annual Review	Revised to include reference to current emergency contract	7/20
Ad Hoc Review	Revised to include all claims processing contract language in current emergency contract	3/21
Annual Review	No Revisions	6/21
Annual Review	Emergency contract update language taken from Amendment 5	6/22
Annual Review	Reformatted to latest Policy Template 2023 Contract language updates	3~~2~~/23

POLICY AND PROCEDURE APPROVAL

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