POLICY AND PROCEDURE

DEPARTMENT: Customer Service	**DOCUMENT NAME:** Retroactive Reimbursement
PAGE: 1 of 7	**REPLACES DOCUMENT:** N/A
APPROVED DATE: 05/2015	**RETIRED:**
EFFECTIVE DATE: 04/2015	**REVIEWED/REVISED:** 04/15, 5/16, 4/17, 4/18, 4/19, 2/20, 10/20, 11/21
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.MBRS.21

SCOPE:
Health Plan Customer Service.

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

POLICY:
~~Beginning Feb. 1, 2015, m~~Managed care organizations (MCOs) are responsible for processing retroactive reimbursement requests submitted by Medicaid enrollees. Medicaid enrollees may be directly reimbursed~~ment~~ for part or all of any medical expenses paid by them ~~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 benefits offered by the MCOs are not eligible for reimbursement.

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

The MCO is 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 requests for reimbursement of covered Medicaid services. In cases of a retroactive payment involving~~ other insurance~~third party liability, 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 an enrollee ~~member~~ welcome letter. The welcome letter must include the following policies and provide the date the request is due:

- ~~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.~~

- ~~Proof of payment must be received from the member by the MCO within 15 days of the request for reimbursement.~~
- ~~However, if the member requests an extension on this time limit it shall be provided, not to exceed 30 days.~~
- 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 the MCO 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.

Changes to existing documents 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.
- The MCO has verified that the provider is enrolled with the MCO 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.
- ~~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 bills must be for medical care, services, ~~and~~or supplies covered by Medicaid at the time the service was delivered. ~~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~~ enrollee has not received reimbursement from Medicaid or the Medicaid provider or ~~nor~~ received payment in full by a third-party entity.
- The ~~member~~ enrollee must provide proof of payment to the MCO. Bills which were paid in full by a third party (e.g. ~~such~~ Medicare, ~~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 a requirement ~~required~~ that continuing liability of the ~~member~~ enrollee be verified.

Reimbursements Involving Third Party Liability

The MCO should use 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.

The MCO shall require enrollees to submit all of the required documentation listed below within the timeframes specified above

Required Documentation

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

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~~LDH 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~~ 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 ~~member~~ 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
- ~~Amount of billed charges and verification of payment, and~~
- Proof of payment by any Private Insurance – explanation of benefits (EOB), Aand**, 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). ~~proof of medical necessity from a physician and prescription for each item if one was issued.~~
- 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.

~~A request for additional documentation may be necessary.~~

If the MCO determines that additional information is needed from the enrollee, the MCO shall mail a Recipient Verification Request Form to the enrollee within three business days of the receipt of the initial request.

The enrollee shall be 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.

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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 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.~~
- Unpaid bills - the enrollee should present his or her 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 the MCO.

Processing Timeframes

MCOs must follow 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, the MCO shall 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 must include a clear explanation of the reason(s) for ineligibility for reimbursement.

Requests received by the MCOs for reimbursement of payment for carved-out services must be submitted to LDH within five business days of receipt for processing by LDH.

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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.

REFERENCES:
Louisiana Department of Health and Hospitals Health Plan Advisory 15-1, March 18, 2015
LDH MCO Manual – Enrollee Retroactive Reimbursement

ATTACHMENTS:

DEFINITIONS:

REVISION LOG	***DATE***
New Policy from DHP Adv 15-1	5/15
No revisions	5/16
Changed DHH to LDH	4/17
Reviewed with no changes	4/18
Reviewed with no changes	4/19
Removed the word “to” from the purpose statement.	2/20
No Revisions	10/20
No Revisions	11/21
Added Tracking and Reporting section	8/22
Updated all Bills Not Eligible for Reimbursement section	8/22
Added Processing Time Frames Section	8/22
Added reference to LDH MCO Manual – Enrollee Retroactive Reimbursement	8/22
Updated policy section to align with language in the MCO Manual	8/22
Updated procedure section to align with the language in the MCO Manual. Added in three bullets to clarify welcome letter expectations	8/22
Updated all reimbursement criteria to align with the MCO Manual	8/22

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Added language related to Reimbursements Involving Third Party Liability	8/22
Updated all required documentation section to align with the MCO manual	8/22
Grammatical Correction	03/23

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer is considered equivalent to a physical signature.