Government Business Division
Policies and Procedures

Section (Primary Department) **Claims**		**SUBJECT (Document Title)** **Claims Interest Payments – LA**	
Effective Date February 1, 2012	**Date of Last Review** February 25, 2022	**Date of Last Revision** ~~March 1, 2021~~November 2, 2022	**Dept. Approval Date** ~~February 25, 2022~~November 2, 2022
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☐ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☒ Louisiana	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Missouri	☐ South Carolina	☐ West Virginia
	☐ Indiana	☐ Nebraska		

PURPOSE:

To define the Interest Payment requirements as outlined in Louisiana MCO Contract

DEFINITIONS:

Claim: (1) bill for services, (2) a line item of service, or (3) all services for one recipient within a bill.

Clean Claim: A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Denied Claim: A claim for which no payment is made to the network provider by the MCO for any of several reasons, including but not limited to, the claim is for non-covered services, an ineligible provider or recipient, or is a duplicate of another transaction, or has failed to pass a significant requirement in the claims processing system.

Paid Claim: The Company or any subcontractor sends the provider a check as full satisfaction of the allowable portion of the claim; or credit the provider against any outstanding balance owed.

Processed Claim: The Company or any subcontractor sends the provider a written or electronic remittance advice or other written or electronic notice confirming the claim was paid or partially/totally denied. Notification shall specify all known reasons for the denial, and any required information or documentation required for claim processing.

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PROCEDURE:

If approved claims are not paid within specified turnaround timeframes, Healthy Blue will pay interest on the claim at 12% per annum calculated daily for the full period in which interest is owed.

The MCO shall ensure that all provider claims are processed according to the following timeframes.

Within five (5) business days of receipt of a claim, the MCO shall 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.

1) Ensure that ninety (90) percent of clean claims for payment of services delivered to a member are paid by the MCO to the provider within fifteen (15) ~~business~~ calendar days of the receipt of such claims.
2) Process and if appropriate, pay within thirty (30) calendar days, one hundred (100%) percent of all provider claims for covered services delivered to a member.
3) Fully adjudicate (pay or deny) all pended claims within (60) calendar days of the date of receipt.
4) Rejected claims
5) Ensure that if a claim is partially or totally denied on the basis the provider did not submit required information or documentation with the claim, then the appropriate written or electronic notice will specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall not constitute a new claim for purposes of establishing the timely filing for claims processing.

Claims Reprocessing:

1)If Elevance or LDH or its subcontractors or Providers discover errors made by the Elevance when a claim was Adjudicated, Elevance shall make corrections and reprocess the claim within fifteen (15) Calendar Days of discovery or notification, or if circumstances exist that prevent Elevance from meeting this time frame, by a specified date subject to LDH written approval.

2)Elevance shall 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) Calendar Day claims reprocessing deadline or the specified deadline approved by LDH in writing, whichever is later. Elevance shall automatically recycle all impacted claims for all providers and shall not require the provider to resubmit the impacted claims.

REFERENCES:

- Louisiana Health Contract Sections 17.2.1, 17.2.1.1,17.2.1.2, 17.2.1.3, 17.2.1.4, 17.2.2.1, 17.2.2.2, 17.3.3, 2.18.2.1.1, 2.18.5.3,
- Prompt Pay Requirements – LA

RESPONSIBLE DEPARTMENTS:

Primary Department – Claims

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
04/28/2015	• 2015 Contract language updated • Placed on the generic template
04/28/2016	• For annual review • 2014 contract language removed to read MCO Bayou Contract
05/04/2017	• For annual review • Definitions updated and placed in alphabetical order • Word Bayou removed throughout policy
04/27/2018	• For annual review • Amerigroup changed to Healthy Blue
04/01/2019	• For annual review • Minor edit to procedure section with current contract language • Reference section updated • Provider Reimbursement removed as secondary department
03/05/2020	• For annual review; no changes
03/01/2021	• For annual review • Procedure 2) updated to reflect the change from 99% to 100% per Amendment 3
02/25/2022	• Annual Review; no changes
11/02/2022	• Off-Cycle Review for LA Rebid 2023 Readiness • Updated procedure and references • Updated to reflect SLA, Interest payment, and reprocessing