POLICY AND PROCEDURE

DEPARTMENT: Claims	**DOCUMENT NAME**: Provider Reimbursement
PAGE: 1 of 6	**REPLACES DOCUMENT:**
APPROVED DATE: 7/15/15	**RETIRED:**
EFFECTIVE DATE: 7/15	**REVIEWED/REVISED:** 11/15, 6/16, 6/17, 6/18, 6/19, 7/20
PRODUCT TYPE: All	**REFERENCE NUMBER:** LA.CLMS.02

SCOPE:
Louisiana Healthcare Connections (PLAN and MCO)

PURPOSE:
The purpose of this policy is to clearly define the PLAN/MCO guidelines for Provider Reimbursement.~~.~~

POLICY:

Provider Reimbursement The PLAN/MCO shall administer an effective, accurate and efficient claims processing system that adjudicates provider claims for covered services that are filed within the time frames specified by the current ~~**2014 RFP**~~ **Louisiana Medicaid MCO Emergency Contract** and in compliance with all applicable State and Federal laws, rules and regulations.

PROCEDURE:

1. **DRG Reimbursement Methodology**
   The system shall have the capacity to group claims and to reimburse inpatient hospital services under a Diagnosis Related Grouping (DRG) methodology as defined by LDH within 180 days of notification by LDH that such reimbursement method is required.

2. **Minimum Reimbursement to In-Network Providers**

   The MCO shall provide reimbursement for defined core benefits and services provided by an in-network provider. The MCO rate of reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on the date of service or its equivalent (such as a DRG case rate), unless mutually agreed to by both the plan and the provider in the provider contract. The MCO shall not enter into alternative reimbursement arrangements with Physicians without written prior approval from LDH.

~~2.~~**3. Reimbursement to Out-of-Network Providers**

   a. The PLAN shall make payment for covered emergency and post-stabilization services that are furnished by providers that have no arrangements with the PLAN for the provision of such services. The

PLAN shall reimburse the provider one hundred percent (100%) of the Medicaid rate for emergency services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement by the PLAN to out-of-network providers for the provision of emergency services shall be no more than the Medicaid rate.

b. For services that do not meet the definition of emergency services, the PLAN is not required to reimburse more than 90% of the published Medicaid rate in effect on the date of service to out-of-network providers to whom they have made at least three (3) documented attempts (as defined in Glossary) to include the provider in their network (except as noted in Section 9.2). The PLAN may require prior authorization of out-of network services, unless services are required to treat an emergency medical condition.

4. FQHC/RHC Contracting and Reimbursement

The PLAN shall reimburse contracted FQHC/RHC the Prospective Payment System (PPS) rate in effect on the date of service for each encounter.

The MCO shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without written prior approval from LDH.

~~3.~~5. Capitation Reimbursement

To the extent that the provider contract requires compensation of a provider on a capitation basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than the time period specified in the provider contract between the provider and the PLAN, or if a time period is not specified in the contract:

a. The tenth (10th) day of the calendar month if the payment is to be made by a contractor, or

b. If the PLAN is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting member roster information from LDH.

~~4.~~6. Inappropriate Payment Denials

~~**If the PLAN has a pattern of inappropriately denying or delaying provider payments for services, the PLAN may be subject to suspension of new enrollments, sanctions, contract cancellation, or refusal to contract in a future time period. This applies not only to situations where LDH has**~~

~~ordered payment after appeal but to situations where no appeal has been made (i.e. LDH is knowledgeable about the documented abuse from other sources).~~

If the PLAN has a pattern, as determined by LDH, of inappropriately denying, delaying, or recouping provider payments for services, the PLAN may be subject to suspension of new enrollments, monetary penalties equal to 1.5 times the value of the claims inappropriately denied, delayed, or recouped, contract cancellation, or refusal to contract in a future time period. This applies not only to situations where LDH has ordered payment after appeal but to situations where no appeal has been made (i.e. LDH is knowledgeable about the documented abuse from other sources).

~~5.~~**7. Payment for Emergency Services and Post-stabilization Services**

~~a. The PLAN shall reimburse providers for emergency services rendered without a requirement for service authorization of any kind.~~

~~b. The PLAN's protocol for provision of emergency services must specify that emergency services will be covered when furnished by a provider with which the PLAN does not have a subcontract or referral arrangement.~~

~~c. The PLAN may not limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms.~~

a) The PLAN shall not deny payment for treatment when a representative of the PLAN instructs the member to seek emergency services.

b) The PLAN shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider or PLAN of the member's screening and treatment within 10 calendar days of presentation for emergency services.

c) The PLAN shall be financially responsible for emergency medical services, including transportation, and shall not retroactively deny a claim for emergency services, including transportation, to an emergency provider because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.

~~6.~~8. Emergency Medical Conditions

The PLAN shall not deny payment for treatment obtained when a member had an emergency medical condition including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of emergency medical condition.

~~7.~~9. Non-Payment for Specified Services

a. ~~7.1~~ **LEERS** The PLAN shall deny payment to providers for deliveries occurring before 39 weeks without a medical indication. PLAN will use LEERS data as directed by the state to process claims for all deliveries occurring before 39 weeks.

b. ~~7.2~~ **Provider Preventable Conditions** The PLAN shall deny payment to providers for Provider Preventable Conditions as defined by LDH in Section 25.8 of the Louisiana Medicaid Program Hospital Services Provider Manual. **The PLAN shall require all providers to report provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made. The MCO shall report all identified provider preventable conditions to LDH in a format specified by LDH.**

~~8.~~10. Payment for Newborn Care

The PLAN shall cover all newborn care rendered within the first month of life regardless if provided by the designated PCP or another network provider. The PLAN shall compensate, at a minimum, ninety percent (90%) of the Medicaid fee-for-service rate in effect for each service coded as a primary care service rendered to a newborn member within thirty days of the member's birth regardless of whether the provider rendering the services is contracted with the PLAN, but subject to the same requirements as a contracted provider.

~~9.~~11. Payment for Hospital Services

The ~~MCO~~ **PLAN** is not responsible for reimbursement of Graduate Medical Education (GME) payments or Disproportionate Share Hospital (DSH) payments to providers. The MCO must use the increased hospital funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in Appendix G – Mercer Certification, Rate Development Methodology and Rates, for reimbursement of inpatient and outpatient hospital services.

~~10.~~12. **Payment for Ambulance Services**

~~**The MCO must use the increased ambulance services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in Appendix G Contract Attachment D – Mercer Certification, Rate Development Methodology and Rates, for reimbursement of ambulance services.**~~

The PLAN must use the increased ambulance services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in Attachment D of the emergency contract – Rate Certification, for reimbursement of ambulance services.

13.

~~11.~~14. **Payment for Physician Services**

~~**The MCO must use the increased physician services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in Appendix G Contract Attachment D – Mercer Certification, Rate Development Methodology and Rates, for reimbursement of physician services.**~~

The PLAN must use the increased physician services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Payment, as detailed in Attachment D of the emergency contract – Rate Certification, for reimbursement of physician services.

REFERENCES:

PLAN-~~**2014 RFP**~~**2020 Louisiana Medicaid MCO Emergency Contract ~~(Amendment 4)~~** – Sections 9.0, ~~**9.3.1-9.3.2, 9.5.4, 9.5.8-9.5.8.1, 9.5.8.2, 9.6, 9.7.1-9.7.3, 9.7.5, 9.8.6, 9.9, 9.11, 9.12**~~**9.1, 9.2, 9.3, 9.3, 9.5**

ATTACHMENTS:

DEFINITIONS:

REVISION LOG	**DATE**
• Scope Section – added “and MCO” to define MCO in sections 9-11. • Purpose Section – added “/MCO” to define MCO in sections 9-11.	• 11/5/15 • 11/5/15 • 11/5/15

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• Policy Section – added "/MCO" to define MCO in sections 9-11. • Added Section 9 – Payment for Hospital Services • Added Section 10 – Payment for Ambulance Services • Added Section 11 – Payment for Physician Services • Added the attached document name in the "ATTACHMENT" section. • Changed "Senior Director of Network Accounts" to "Senior Manager of Claims & Contract Support". • Added "Appendix G" to both 9. Payment for Ambulance Services and 10. Payment for Physician Services. • Added "Amendment 4" and "9.0" to REFERENCES and Deleted ATTACHMENTS. • Changed back from "Senior Manager of Claims & Contract Support to "Senior Director of Network Accounts". • Changed DHH to LDH	• 11/5/15 • 11/5/15 • 11/5/15 • 11/5/15 • 11/5/15 • 6/21/16 • 6/21/16 • 6/21/16 • 6/16
No revisions	6/17
No revisions	6/18
No revisions	6/19
Updated references per emergency contract	**7/14/2020**
Added 2020 Louisiana Medicaid Emergency Contract updates	**7/14/2020**

POLICY AND PROCEDURE APPROVAL

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

Senior Director of Network Accounts: _____Electronic Signature on File_____