POLICY AND PROCEDURE

DEPARTMENT: Claims	**DOCUMENT NAME**: Claims Payment Reporting and Auditing
PAGE: 1 of 4	**REPLACES DOCUMENT:**
APPROVED DATE: 7/15/15	**RETIRED:**
EFFECTIVE DATE: 7/15	**REVIEWED/REVISED:** 6/16, 10/16, 6/17, 6/18, 6/19, 7/20
PRODUCT TYPE: All	**REFERENCE NUMBER:** LA.CLMS.04

SCOPE:
Louisiana Healthcare Connections (PLAN)

PURPOSE:
The purpose of this policy is to clearly define the PLAN guidelines for Claims Payment accuracy reporting and auditing.

POLICY:

Claims Management- Claims payment accuracy reporting and auditing must be performed in adherence to information exchange and data management requirements specified in Section 17 of the current **Louisiana Medicaid MCO emergency contract** and in compliance with all applicable State and Federal laws, rules and regulations.

PROCEDURE:

1. **Post Payment Claim Surveys**- Surveys may be performed at any point after a claim has been paid. This sampling may be performed by mail, telephonically or in person (e.g., case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim.

2. **Claims Payment Accuracy Report-** On a monthly basis, the PLAN shall submit a claims payment accuracy percentage report to LDH. The report shall be based on an audit conducted by the PLAN. The audit shall be conducted by an entity or staff independent of claims management as specified in **the Louisiana Medicaid MCO Emergenct Contract**, and shall utilize a randomly selected sample of all processed and paid claims upon initial submission in each month. A minimum sample consisting of two hundred (200) to two hundred-fifty (250) claims per year, based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission.

3. **Vendor Claim payment accuracy report-** If the PLAN sub-contracted for the provision of any covered services, and the PLAN's sub-contractor is responsible for processing claims, then the PLAN shall submit a claims payment accuracy percentage report for the claims processed by the sub-contractor.

4. **Minimum attributes** to be tested for each claim selected shall include:

a. Claim data is correctly entered into the claims processing system;
b. Claim is associated with the correct provider;
c. Proper authorization was obtained for the service;
d. Member eligibility at processing date correctly applied;
e. Allowed payment amount agrees with contracted rate;
f. Duplicate payment of the same claim has not occurred;
g. Denial reason is applied appropriately;
h. Co-payments are considered and applied, if applicable;
i. Effect of modifier codes correctly applied; and
j. Proper coding.

5. **Results of testing** at a minimum should be documented to include:

a. Results for each attribute tested for each claim selected;
b. Amount of overpayment or underpayment for each claim processed or paid in error;
c. Explanation of the erroneous processing for each claim processed or paid in error;
d. Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and
e. Claims processed or paid in error have been corrected.

6. **Claims Summary Reports**- The PLAN must submit monthly, Claims Summary Reports of paid and denied claims, to LDH by claim type. Instructions are provided in the **Systems Companion Guide**.

7. **Claims Audit Requirements-** The PLAN shall ensure Systems facilitate the auditing of individual claims. Adequate audit trails shall be provided throughout the Systems.

8. **State Audits-**The PLAN shall provide to state auditors (including legislative auditors), or their designee, upon written request, files for any specified accounting period that a valid Contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with LDH and/or state auditor's facilities. The PLAN shall provide information necessary to assist the state auditor in processing or utilizing the files.

9. **Auditor's findings-** if they point to discrepancies or errors, the PLAN shall provide a written corrective action plan to LDH within ten (10) business days of receipt of the audit report.

10. **Audit Coordination and Claims Reviews-** The PLAN shall coordinate audits with the Department or designee and respond within thirty (30) calendar days of a request by the Department regarding the PLAN's review of a specific provider and/or claim(s), and the issue reviewed.

11. **Overpayments identified**- 17.12.4.2
In the event the Department or its designee identifies an overpayment, the MCO shall have ten (10) business days from the date of notification of overpayments to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department or designee. The MCO shall not correct the claims upon notification by the Department or designee, unless directed to do so by the Department.

12. **Claims Review**- LDH reserves the right to review any claim paid by the PLAN or designee. The PLAN has the right to collect or recoup any overpayments identified by the PLAN from providers of service in accordance with existing laws or regulations. If an overpayment is identified by the State or its designee after a one year period from payment, the PLAN will collect and remit the overpayment to LDH. In the event the PLAN does not collect mispayments from the provider within thirty (30) calendar days of notification of the overpayment, the PLAN shall refund the overpayment to the Department. Failure by the PLAN to collect from the provider does not relieve the PLAN from remitting the identified overpayment to LDH.

13. **Independent Audits of Systems -The MCO shall submit an independent SOC 2 Type II system audit. The audit should review system security, system availability, system confidentiality and processing integrity for the Louisiana Medicaid line of business. The audit period shall be 12 consecutive months, aligning with the MCO's fiscal year, with no breaks between subsequent audit periods. The MCO shall supply the Department with an exact copy of the SOC 2 Type II independent audit no later than six (6) months after the close of the MCO's fiscal year. The MCO shall deliver to LDH a corrective action plan to address deficiencies identified during the audit within 30 business days of the MCO's receipt of the final audit report.**

REFERENCES:

PLAN- **Louisiana Medicaid MCO emergency contract** – Sections 17.5.3, 17.8, 17.8.1, 17.8.2, 17.8.3, 17.8.4, **17.12, 17.12.1, 17.12.2, 17.12.3, 17.12.4**

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ATTACHMENTS:

DEFINITIONS:

REVISION LOG	**DATE**
Deleted "DHH PLAN" from 6. Claims Summary Reports Added 17.11 to the REFERENCES Changed DHH to LDH Deleted 2014 from Claims Management Policy description Deleted verbiage in item #7 per Amendment #6 of RFP Added and/or Amendment #6 to the REFERENCES	6/16 10/16
No revisions	6/17
No revisions	6/18
No revisions	6/19
Added section 17.12.3 Independent Audit of Systems	**7/14/2020**
Updated references as per Louisiana Medicaid MCO Emergency Contract	**7/14/2020**
Deleted mispayment verbage and added overpayment language from emergency contract	**7/14/2020**
Added reference to Louisiana Medicaid MCO Emergency Contract	**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_____