POLICY AND PROCEDURE

POLICY NAME: Provider Reimbursement	**POLICY ID:** LA.CLMS.02
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA:** Claims
EFFECTIVE DATE: 07/01/2015	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 11/15, 6/16, 6/17, 6/18, 6/19, 7/20, 3/22, 12/22, 4/23	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
This policy outlines the process and procedures for provider reimbursement.

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

SCOPE:
Louisiana Healthcare Connections (~~PLAN~~LHCC ~~and MCO~~)

DEFINITIONS:

POLICY:
~~The PLAN/MCO~~LHCC ~~shall~~ administers an effective, accurate and efficient claims processing system that adjudicates provider claims for ~~PLANMCO~~LHCC covered services that are filed within the time frames specified in its contract with LDH and in compliance with all applicable State and Federal laws, rules, policies, procedures, manuals, and regulations.

PROCEDURE:

1. **Minimum Reimbursement to In-Network Providers (2.11.1)**
   ~~The PLANMCO~~LHCC ~~shall~~ provides reimbursement for defined core benefits and services provided by ~~an~~ in-network providers. ~~The PLAN~~LHCC's~~MCO~~ rate of reimbursement ~~shall be~~is no less than the published Medicaid fee-for-service rate ~~in~~ in effect on the date of service or that is contained on the weekly procedure file sent by the FI, or its equivalent ~~(such as a DRG case rate)~~, unless mutually agreed to by both ~~the plan~~LHCC and the provider in the Network ~~p~~Provider ~~contract~~Agreement. ~~The PLANMCO~~LHCC ~~shall~~will not enter into alternative reimbursement arrangements with Physicians without written prior approval from LDH.
   - For cost-based services, the ~~PLAN's~~ rate of reimbursement shall be no less than the published FFS Rate adjusted by the cost-based settlement.
   - For cases eligible for Outlier payments, the ~~PLAN's~~ rate of reimbursement shall be no less than the published FFS Rate plus the additional calculated outlier amount.

2. **DRG Reimbursement Methodology (2.11.1.3)**
   The system ~~shall have~~has the capacity to group claims and to reimburse inpatient hospital services under a Diagnosis Related Grouping (DRG) methodology as defined by LDH within 180 Calendar days of notification by LDH that such reimbursement method is required. LDH shall be responsible for establishing DRG rates. Upon implementation of the methodology, ~~the PLAN shall~~LHCC's rate of reimbursement shall reimburse no less than the DRG rate established by LDH, unless mutually agreed to by both ~~the plan~~LHCC and the provider in the Network ~~p~~Provider ~~contract~~Agreement.

3. **Reimbursement to Out-of-Network Providers (2.11.4)**
   a. ~~The PLAN shall~~LHCC makes payments for covered emergency and post-stabilization services that are furnished by providers that have no contractual arrangements with ~~the PLAN~~LHCC for the provision of such services. ~~The PLAN~~LHCC shall reimburse the provider one hundred percent (100%) of the Fee-for-Service (FFS)~~Medicaid~~ rate for Emergency Services. In compliance with Section 6085 of the Deficit Reduction Act (DRA) of 2005, reimbursement by ~~the PLAN~~LHCC to out-of-network providers for the provision of E~~e~~mergency S~~s~~ervices shall be no more than the FFS~~Medicaid~~ rate.
   b. For services that do not meet the definition of Emergency Services, ~~the PLAN~~LHCC shall compensate, at a minimum, ninety percent (90%) of the published FFS~~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 to include in their network (except as noted in this section for FQHCs, RHCs and IHS providers). ~~The PLAN~~LHCC may require Prior Authorization of out-of-network services, unless services are required to treat an Emergency Medical Condition.

c. ~~The PLAN~~LHCC shall not make payments for Community Psychiatric Support Treatment (CPST) or Psychosocial Rehabilitation (PSR) services that are furnished to Enrollees by providers that are out-of-network. LHCC~~The PLAN~~ may make payments for CPST or PSR services only to those providers who are:
    1. credentialed
    2. participating in the provider network of ~~the PLAN~~LHCC for provisions of such services, or
    ~~2.~~3. who are licensed and accredited, AND
    ~~3.~~4. have a single case agreement (SCA) with ~~the PLAN~~LHCC.

d. ~~The PLAN~~LHCC shall reimburse out-of-Network Providers for the provision of services required by the *Continuity of Care* section at the in-network rate, in accordance with the *Minimum Reimbursement to In Network Providers* section.

4. Effective Date of Payment for New Enrollees (2.11.5)

a. LHCC is responsible for payment of MCO Covered Services from an Enrollee's effective date of Enrollment with LHCC.

~~4.~~5. Provider State Enrolled Reimbursement (2.11.1.6)

a. Reimbursement shall be provided for dates of service on or after the state enrollment effective date for state enrolled providers with effective dates equal to or less than ninety (90) calendar days prior to execution of ~~the Contractor's~~LHCC'S Network Provider Agreement.

b. Reimbursement shall be provided for dates of services on or after the Network Provider Agreement execution date for state enrolled providers with effective dates greater than ninety (90) calendar days prior to execution of ~~the Contractor's~~LHCC'S Network Provider Agreement.

~~b.~~c. In either case, if a provider would otherwise be eligible for reimbursement at an earlier date under La. R.S. 46:460.62, then reimbursement shall be provided for dates of service on or after that date.

~~5.~~6. Mental Health Rehabilitation (MHR) Reimbursement (2.9.9.4)

a. Claims submitted for MHR services shall include rendering provider NPIs and other ~~Contractor~~ LHCC required identifiers regardless of whether the rendering staff is licensed or unlicensed. ~~The PLAN~~LHCC shall configure internal systems to deny claims for services when rendering providers and NPIs are denoted on Claims for service that have not been credentialed and approved by ~~the Contractor~~LHCC.

~~6.~~7. Federally Qualified Health Center (FQHC) / Rural Health Clinic (RHC) Contracting and Reimbursement (2.11.2)

~~The PLAN~~LHCC shall reimburse contracted FQHC/RHC at least the amount LDH would pay for such services through FFS as defined by the Prospective Payment System (PPS) rate in effect on the date of service for each Encounter or an alternative payment methodology approved by LDH in writing. ~~The~~ LHCC shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without written prior approval from LDH. If ~~the PLAN~~LHCC is unable to contract with an FQHC or RHC, ~~the PLAN~~LHCC is not required to reimburse that FQHC or RHC without P~~p~~rior ~~approval~~ Authorization for out-of-network services unless:

a. The medically necessary services are required to treat an ~~e~~Emergency ~~m~~Medical ~~c~~Condition; or
b. FQHC/RHC services are not available through at least one MCO within LDH's established distance travel standards.

~~7.~~8. Indian Health Service (IHS) Providers ~~(IHS)~~ (2.11.3)

~~The PLAN~~LHCC shall reimburse the IHS at the annual rates published in the Federal Register by the Indian Health Services (IHS). IHS issues the payment rate based on a calendar year that will be effective retroactive to e January 1st of that year. ~~The PLAN~~LHCC will recycle claims for the calendar year to capture the adjusted rate. See 42 CFR §438.14(c).

~~8.~~9. Inappropriate Payment Denials or Recoupments (2.11.7)

If ~~the PLAN~~LHCC has a pattern, as determined by LDH, of inappropriately denying, delaying, or recouping provider payments for services, ~~the PLAN~~LHCC may be subject to suspension of new ~~e~~Enrollments, ~~m~~Monetary ~~p~~Penalties equal to one-half (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).

~~9.~~10. Payment for Emergency Services and Post-stabilization Services (2.11.8)

~~The PLAN~~LHCC shall reimburse providers for Emergency Services rendered without a requirement for Service Authorization of any kind

~~The PLAN's~~LHCC's protocol for provision of Emergency Services ~~shall~~ specifies~~y~~ that Emergency Services shall be covered when furnished by a provider with whom the Contractor does not have a Network Provider Agreement or referral arrangement.

~~The PLAN~~LHCC may not limit what constitutes an Emergency Medical Condition on the basis of diagnoses or symptoms.

~~The PLAN~~LHCC shall not deny payment for treatment obtained under either of the following circumstances:

a. An Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or ~~The PLAN shall not deny payment for treatment when a representative of the PLAN instructs the member to seek emergency services.~~

b. A representative of ~~t~~LHC~~he~~ C~~ontractor~~ instructs the Enrollee to seek Emergency Services.

~~The PLAN shall reimburse providers for Emergency Services rendered without a requirement for Service Authorization of any kind.~~

~~The PLAN~~LHCC shall not refuse to cover E~~e~~mergency ~~s~~Services based on the emergency room provider, hospital, or fiscal agent not notifying the ~~member~~Enrollee's primary care provider or ~~PLAN~~ LHCC of the ~~member's~~ Enrollee's screening and treatment within 10 calendar days of presentation for ~~e~~Emergency ~~s~~Services.

~~The PLAN~~LHCC shall be financially responsible for ~~e~~Emergency ~~medical s~~Services, including transportation, and shall not retroactively deny a claim for ~~e~~Emergency ~~s~~Services, including transportation, to an emergency provider because the condition, which appeared to be an ~~e~~Emergency ~~m~~Medical ~~c~~Condition under the prudent layperson standard, was subsequently determined to be non-emergency in nature.

~~The Contractor~~LHCC is financially responsible for post-stabilization care services, as specified in 42 CFR §438.114(e) and §422.113(c), obtained within or outside the network that are:

a. Pre-approved by a Network Provider or other ~~Contractor~~LHCC representative; or
b. Not pre-approved by a Network Provider or other ~~Contractor~~LHCC representative, but:
    1. Administered to maintain the ~~e~~Enrollee's stabilized condition within one (1) hour of a request to ~~the PLAN~~LHCC for pre-approval of further post-stabilization care services;
    2. Administered to maintain, improve or resolve the ~~e~~Enrollee's stabilized condition if ~~the PLAN~~LHCC:

- Does not respond to a request for pre-approval within one (1) hour;
- Cannot be contacted; or
- LHCC~~PLAN~~'s representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a network physician is not available for consultation. In this situation, ~~the Contractor~~LHCC shall give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is

reached or one of the criteria of 42 CFR §422.113(c)(3) is met.

3. Are for post-stabilization hospital-to-hospital ambulance transportation of Enrollees with a behavioral health condition, including hospital to behavioral health specialty hospital.

The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on ~~the Contractor~~LHCC as responsible for coverage and payment as per 42 CFR §438.114(d). ~~The Contractor's~~LHCC's financial responsibility ends for post stabilization care services it has not pre-approved when:

a. A network physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;
b. A network physician assumes responsibility for the Enrollee's care through transfer;
c. A representative of ~~the Contractor~~LHCC and the treating physician reach an agreement concerning the Enrollee's care; or
~~a.~~d. The Enrollee is discharged.

~~10. 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.~~

11. Non-Payment for Specified Services (2.11.9)

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

12. Provider Preventable Conditions (PPCs) (2.11.10)

~~The PLAN~~LHCC shall deny payment to providers for Provider Preventable Conditions (PPCs) that meet the following criteria:

a. Is identified in the State Plan
b. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
c. Has a negative consequence for the beneficiary
d. Is auditable; and
e. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.

~~The PLAN~~LHCC ~~shall~~ requires all providers to report provider-preventable conditions associated with claims for payment or enrollee~~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. PPCs should be identified on the Encounter file via the Present on Admission (POA) indicators.

13. Payment for Pharmacy Services (2.11.11)

~~The PLAN~~LHCC and ~~the Plans~~LHCC's PBM are prohibited from reimbursing pharmacies that are owned by ~~the Plan~~LHCC and/or the PBM at a rate higher than pharmacies that are not owned by ~~the Plan~~LHCC and/or the PBM.

~~13.~~14. Payment for Newborn Care (2.11.12)

~~The PLAN~~LHCC shall cover all newborn care rendered within the first month of life regardless if provided by the designated PCP or another ~~n~~Network ~~p~~Provider. ~~The PLAN~~LHCC 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 calendar days of the ~~member's~~ Enrolee's birth regardless of whether the provider rendering the services is contracted with ~~the PLAN~~LHCC, but subject to the same requirements as a ~~contracted~~ Network ~~p~~Provider.

~~14.~~15. Payment for Hospital Services (2.11.13)

~~The PLAN~~LHCC is not responsible for reimbursement of Graduate Medical Education (GME) payments or Disproportionate Share Hospital (DSH) payments to providers. LDH will provide a uniform percentage increase for in-state providers of inpatient and outpatient hospital services (excluding freestanding psychiatric hospitals, freestanding rehabilitation hospitals, and long-term acute care, psychiatric services, and rehabilitation services for both inpatient and outpatient hospital services for that rating period. This directed payment arrangement shall be detailed in Attachment D, *Actuarial Rate Certification Letter*.

LDH shall provide a quarterly interim direct payment report to ~~the PLAN~~LHCC for each quarter, which identifies qualified hospitals and payment for that quarter. ~~The PLAN~~LHCC shall pay the interim directed payment as specified in that report within ten (10) business days of receipt of LDH report, unless otherwise directed in writing by the Hospital and Facility Finance Director or the LDH Undersecretary. LHCC shall not deviate from the payments set forth in the quarterly interim direct payment report, unless otherwise directed in writing by the Hospital and Facility Finance Director or the LDH Undersecretary.~~.~~

The direct payments must be based on actual utilization and delivery of services. As such, within twelve months of the of SFY, LDH will perform a reconciliation and provide ~~the PLAN~~LHCC the adjustments to be made to each qualified hospitals' next quarterly interim directed payment.

~~15.~~16. Payment for Ambulance Services (2.11.14)

~~The PLAN~~LHCC shall~~must~~ use the increased ambulance services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Pricing, or any successive payment model, as detailed in Attachment D, *Actuarial Rate Certification Letter,* for reimbursement of ambulance services in compliance with 42 CFR §438.6.~~.~~

~~16.~~17. Payment for Physician Services (2.11.15)

~~The PLAN~~LHCC must use the increased physician services funds received above the base rate (subject to risk adjustment) to the Full Medicaid Pricing, or any successive payment model, as detailed in Attachment D, *Actuarial Rate Certification Letter*, for reimbursement of physician services in compliance with 42 CFR~~.~~ §438.6.

18. Federal Responsibility for Payment for SBHS Provided to Enrollees Participating in Coordinated System Care (2.11.16)

a. ~~The CSoC PLAN~~LHCC shall be responsible for payment to enrolled providers for the provision of SBHS, with the exception of PRTF, TGH, and SUD Residential treatment services (ASAM 3.1, 3.2-wm, 3.5 and 3.7 for children under 21 and Levels 3.3 and 3.7-wm for youth aged 21), for each month during which the Enrollee has a 1915(c)/1915(b)(3) Waiver segment on the eligibility file with a begin date on or earlier than the first (1st) Calendar Day of that month, or in the event that an Enrollee transfers between Waivers during the month, but the previous segment began on or earlier than the first (1st) Calendar Day of that month.

b. ~~The CSoC PLAN~~LHCC shall be responsible for payment to enrolled providers for the provision of SBHS through the last day of the month which includes the end date of the 1915(c)/1915(b)(3) segment on the eligibility file.

c. ~~The PLAN~~LHCC shall be responsible for payment to enrolled providers for the provision of SBHS for any month during which the Enrollee has a 1915(c)/1915(b)(3) segment on the eligibility file with a begin date later than the first (1st) Calendar Day of that month.

d. ~~The PLAN~~LHCC shall be responsible for payment of all PRTF, TGH, and SUD Residential treatment services (ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7 for children under 21 and Levels 3.3 and 3.7-wm for youth aged 21) for CSoC enrolled youth.

e. If an Enrollee no longer meets medical necessity criteria for a higher level of care (i.e., inpatient hospital) that was authorized by the ~~CSoC contractor~~LHCC, and ~~the Contractor~~LHCC has authorized PRTF, TGH, or

SUD Residential treatment services (ASAM Levels 3.1, 3.2-wm, 3.5 and 3.7), but is unable to secure placement, ~~the Contractor~~LHCC shall be responsible for assuming the continued authorization of, and payment for, the higher level service until placement is made, regardless of the Enrollee's CSoC Enrollment status, unless the Child and Family Team (CFT) agrees that the Enrollee's behavioral health and/or medical condition is stable enough for the Enrollee to be safely discharged home, and the CFT has made a plan to support the Enrollee and family with outpatient care until placement in residential treatment is secured.

~~**17. Payment for Pharmacy Services**~~

~~The PLAN and the Plans PBM are prohibited from reimbursing pharmacies that are owned by the Plan and/or the PBM at a rate higher than pharmacies that are owned by the Plan and/or the PBM.~~

REFERENCES:
Louisiana Medicaid Attachment A – Model Contract Section 2.9.9.4 and Sections 2.11.1 through 2.11.1~~64~~
Louisiana Medicaid Attachment D – *Actuarial Rate Certification Letter*

ATTACHMENTS:

ROLES & RESPONSIBILITIES:

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

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	Scope Section – added "and MCO" to define MCO in sections 9-11. Purpose Section – added "/MCO" to define MCO in sections 9-11. 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".	11/05/15
Annual Review	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	06/21/16
Annual Review	No revisions	06/23/17
Annual Review	No revisions	06/25/18
Annual Review	No revisions	06/24/19
Annual Review	Updated references per emergency contract Added 2020 Louisiana Medicaid Emergency Contract updates	06/25/20
Annual Review	Updated Section 1 - DRG Reimbursement Methodology as per 2020 Louisiana Medicaid Emergency Contract Updated Section 4 - FQHC/RHC Contracting and Reimbursement as per 2020 Louisiana Medicaid Emergency Contract Added Section 5 – Indian Health Care Providers as per 2020 Louisiana Medicaid Emergency Contract Added references to Louisiana Medicaid MCO Emergency Contract	03/28/22
Ad Hoc Review	Added Section – Out-of-Network CPST/PSR Reimbursement	12/06/22

	Added Section – State Enrolled Provider Reimbursement based on effective dates Added Section – Pharmacy Service Reimbursement Deleted reference to “MCO Emergency Contract” language Added Section – Mental Health Rehabilitation Reimbursement Removed “Capitation Reimbursement” Section. Included Hospital reimbursement language under one section Updated language referencing “Full Medicaid Pricing, or any successive payment model, as detailed in Attachment D, Actuarial Rate Certification Letter” under Payment for Ambulance and Physician Services. Reformatted to latest Policy Template	
Ad Hoc Review	Updated the following sections to better align with LDH Model Contract Section 2.11: Minimum Reimbursement to In-Network Providers Reimbursement to Out-of-Network Providers (changed *Medicaid* to *FFS*) Payment for Emergency Services and Post-stabilization Services (and incorporated previous section 10 into this section Provider Preventable Conditions Payment for Ambulance Services Added Payment for Pharmacy Services (2.11.11) Added Federal Responsibility for Payment for SBHS Provided to Enrollees Participating in Coordinated System of Care Grammatical edits	04/11/23

POLICY AND PROCEDURE APPROVAL

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