PROVIDER ISSUE RESOLUTION

The MCO shall provide options to providers for pursuing resolution of issues. Providers should first seek resolution with the MCO directly prior to engaging LDH or other third parties, except when the MCO has demonstrated a pattern of the same issue reoccurring.

Claim Reconsideration, Appeal, and Arbitration

The MCO shall maintain, in accordance with IB 19-3 or as otherwise approved by LDH, claim dispute procedures for providers who wish to file formal claim reconsideration requests and claim appeals. Procedures should include submission instructions and timelines.

In any instance where a provider claim is denied, the consent of the enrollee who received services shall not be required in order for the provider to dispute the denial of the claim. The provider may pursue a claim dispute on the basis of nonpayment for rendered services under the terms and conditions outlined in their provider contract with the MCO or as otherwise provided by Louisiana law. The enrollee who received the services shall not be required to sign an authorized representative form, or provide other forms of written consent, for the provider to dispute the denied claim for payment. For each denied claim, providers must be notified of the amount and reason for the denial.

In any case where a provider is required to obtain a service authorization on a concurrent or post-service basis, the consent of the enrollee who received the service shall not be required in order for the provider to dispute the denied authorization for service.

Providers who have completed the MCO dispute process and remain dissatisfied with the MCO's determination may submit a written request for arbitration. The request should include decisions from all claim reconsideration requests and claim appeals.

Providers may escalate claim disputes to LDH via e-mail at ProviderRelations@la.gov.

NOTE: Per La. R.S. 46:460.81, an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review.

Independent Review

Independent review is another option for resolution of claim disputes. The Independent Review process may be initiated after claim denial.

NOTE: Per La. R.S. 46:460.81, an adverse determination involved in litigation or arbitration or not associated with a Medicaid enrollee shall not be eligible for independent review.

- The Independent Review process was established by La. R.S. 46:460.81, *et seq*. to resolve claims disputes when a provider believes an MCO has partially or totally denied claims incorrectly. An MCO's failure to send a provider a remittance advice or other written or electronic notice either partially or totally denying a claim within 60 days of the MCO's receipt of the claim is considered a claims denial.

- Independent Review is a two-step process which may be initiated by submitting an Independent Review Reconsideration Request Form to the MCO within 180 calendar days of the Remittance Advice paid, denial, or recoupment date.
- If a provider remains dissatisfied with the outcome of an Independent Review Reconsideration Request, the provider may submit an Independent Review Request Form to LDH within 60 calendar days of the MCO's decision.
- There is a $750 fee associated with an independent review request. If the independent reviewer decides in favor of the provider, the MCO is responsible for paying the fee. Conversely, if the independent reviewer finds in favor of the MCO, the provider is responsible for paying the fee.
- SIU post-payment reviews are not considered claims denials or underpayment disputes, therefore, SIU findings are exempt from the Independent Review Process.
- Additional detailed information and copies of above referenced forms are available on the LDH website [link].

Provider Issue Escalation and Resolution

A provider may desire to escalate an issue to the attention of the MCO's executive team. This may apply to claim or non-claim related issues.

The MCO is required to maintain a Provider Complaint System for in-network and out-of-network providers to dispute the MCO's policies, procedures, or administrative functions. This system should include contacts for filing a formal complaint and then for escalating to management and executive levels. Providers should first seek resolution with the MCO, using these contacts. If a provider is unable to reach satisfactory resolution or get a timely response through the MCO escalation process, direct contact with LDH via ProviderRelations@la.gov is also an option.

If the MCO, LDH, or its subcontractors discover errors made by the MCO when a claim was adjudicated, the MCO shall make corrections and reprocess the claim within fifteen (15) calendar days of discovery, or if circumstances exist that prevent the MCO from meeting this time frame, a specified date shall be approved by LDH. The MCO shall automatically recycle all impacted claims for all providers and shall not require the provider to resubmit the impacted claims.

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