§3511 Prompt Pay of Claims

A. Network Providers. All subcontracts executed by the MCO shall comply with the terms in the contract. Requirements shall include at a minimum:

1. the name and address of the official payee to whom payment shall be made;

2. the full disclosure of the method and amount of compensation or other consideration to be received from the MCO; and

3. the standards for the receipt and processing of claims are as specified by the department in the MCO's contract with the department and department issued guides.

B. Network and Out-of-Network Providers

1. The MCO shall make payments to its network providers, and out-of-network providers, subject to the conditions outlined in the contract and department issued guides.

a. The MCO shall pay 90 percent of all clean claims, as defined by the department, received from each provider type within 15 business days of the date of receipt.

b. The MCO shall pay 99 percent of all clean claims within 30 calendar days of the date of receipt.

c. The MCO shall pay annual interest to the provider, at a rate specified by the department, on all clean claims paid in excess of 30 days of the date of receipt. This interest payment shall be paid at the time the claim is fully adjudicated for payment.

2. The provider must submit all claims for payment no later than 180 days from the date of service.

3. The MCO and all providers shall retain any and all supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state laws.

a. Any such documents shall be retained for a period of at least six years or until the final resolution of all litigation, claims, financial management reviews, or audits pertaining to the contract.

4. There shall not be any restrictions on the right of the state and federal government to conduct inspections and/or audits as deemed necessary to assure quality, appropriateness or timeliness of services and reasonableness of costs.

C. Claims Management

1. The MCO shall process a provider's claims for covered services provided to members in compliance with all applicable state and federal laws, rules and regulations as

well as all applicable MCO policies and procedures including, but not limited to:

a. claims format requirements;

b. claims processing methodology requirements;

c. explanation of benefits and related function requirements;

d. processing of payment errors;

e. notification to providers requirements; and

f. timely filing.

D. Provider Claims Dispute

1. The MCO shall:

a. have an internal claims dispute procedure that is in compliance with the contract and department issued guide and approved by the department;

b. contract with independent reviewers to review disputed claims;

c. systematically capture the status and resolution of all claim disputes as well as all associate documentation; and

d. Report the status of all disputes and their resolution to the department on a monthly basis as specified in the contract and department issued guides.

E. Claims Payment Accuracy Report

1. The MCO shall submit an audited claims payment accuracy percentage report to the department on a monthly basis as specified in the contract and department issued MCO guides.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1589 (June 2011), amended LR 41:938 (May 2015).