NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Managed Care for Physical and Behavioral Health
Independent Review Process for Provider Claims
(LAC 50:I.3111)

The Department of Health, Bureau of Health Services Financing proposes to adopt LAC 50:I.3111 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Act 349 of the 2017 Regular Session of the Louisiana Legislature directed the Department of Health, Bureau of Health Services Financing to establish a process for review of health care provider claims submitted to Medicaid managed care organizations when claim payment determinations are adverse to providers. This legislation further directed the department to: 1) establish a panel for the selection of the independent reviewers; 2) provide for reporting requirements; 3) establish penalties; and 4) related matters.

In compliance with the provisions of Act 349, the department proposes to amend the provisions governing managed care for physical and behavioral health in order to adopt provisions for the independent process for the review of MCO

provider claims payment determinations that are adverse to health care providers.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 31. General Provisions

§3111. Independent Review Process for Provider Claims

A. Right of Providers to Independent Review

1. Pursuant to Act 349 of the 2017 Regular Session of the Louisiana Legislature, for adverse determinations related to claims filed on or after January 1, 2018, a healthcare provider shall have a right to an independent review of the adverse action of the managed care organization (MCO).

2. For purposes of these provisions, adverse determinations shall refer to claims submitted by healthcare providers for payment for services rendered to Medicaid enrollees and denied by a MCO, in whole or in part, or a claim that results in recoupment of a payment from the healthcare provider.

B. Request for Reconsideration

1. A provider shall submit a written request for reconsideration to the MCO. The request shall identify the claim(s) in dispute, the reasons for the dispute, and any

documentation supporting the provider's position or request by the MCO, within 180 days from one of the following dates:

a. the date on which the MCO transmits remittance advice or other notice electronically;

b. 60 days from the date the claim was submitted to the MCO if the provider receives no notice from an MCO, either partially or totally, denying the claim; or

c. the date on which the MCO recoups monies remitted for a previous claim payment.

2. The MCO shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with §3111.B.1, within five calendar days after receipt of the request, and render a final decision by providing a response to the provider within 45 calendar days from the date of receipt of the request for reconsideration, unless another time frame is agreed upon in writing by the provider and the MCO.

C. Independent Review Requirements

1. If the MCO upholds the adverse determination, or does not respond to the reconsideration request within the time frames allowed, the provider may file a written notice with the department requesting the adverse determination be submitted to an independent reviewer. The department must receive the written request from the provider for an independent review within 60 days from the date the provider receives the MCO’s notice of the

decision of the reconsideration request, or if the MCO does not respond to the reconsideration request within the time frames allowed, the last date of the time period allowed for the MCO to respond.

2. The provider shall include a copy of the written request for reconsideration with the request for an independent review. The address to be used by the provider for submission of the request shall be P.O. Box 91283, Bin 32, Baton Rouge, LA 70821-9283.

3. If the MCO reverses the adverse determination pursuant to a request for reconsideration, payment of the claim(s) in dispute shall be made no later than 20 days from the date of the MCO's decision.

4. Subject to approval by the department, a provider may aggregate multiple adverse determinations involving the same MCO when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law.

5. Within 14 calendar days of receipt of the request for independent review, the independent reviewer shall request to be provided all information and documentation submitted for reconsideration regarding the disputed claim or claims within 30 calendar days.

6. If the independent reviewer determines that guidance on a medical issue from the department is required to make a decision, the reviewer shall refer this specific issue to the department for review and concise response to the request within 90 calendar days after receipt.

7. The independent reviewer shall examine all materials submitted and render a decision on the dispute within 60 calendar days. The independent reviewer may request in writing an extension of time from the department to resolve the dispute. If an extension of time is granted by the department, the independent reviewer shall provide notice of the extension to the provider and the MCO.

8. If the independent reviewer renders a decision requiring a MCO to pay any claims or portion of the claims, within 20 calendar days, the MCO shall send the provider payment in full along with 12 percent interest calculated back to the date the claim was originally denied or recouped.

9. Within 60 calendar days of an independent reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the independent reviewer's decision to recover any funds awarded by the independent reviewer to the other party.

D. Independent Review Costs

1. The fee for conducting an independent review shall be paid to the independent reviewer by the MCO within 30 calendar days of receipt of a bill for services. A provider shall, within 10 days of the date of the decision of the independent reviewer, reimburse a MCO for the fee associated with conducting an independent review when the decision of the MCO is upheld. If the provider fails to submit payment for the independent review within 10 days from the date of the decision, the MCO may withhold future payments to the provider in an amount equal to the cost of the independent review, and the department may prohibit that provider from future participation in the independent review process.

2. If the MCO fails to pay the bill for the independent reviewer's services, the reviewer may request payment directly from the department from any funds held by the state that are payable to the MCO.

E. Independent Reviewer Selection Panel

1. The independent reviewer selection panel shall select and identify an appropriate number of independent reviewers and determine a uniform rate of compensation to be paid to each reviewer, not to exceed $2,000 per review.

2. The panel shall consist of the secretary or his/her duly designated representative, two provider representatives and two MCO representatives.

3. Each MCO shall utilize only independent reviewers who are selected in accordance with Act 349 of the 2017 Regular Session of the Louisiana Legislature, and shall comply with the provisions of this Section in the resolution of disputed adverse determinations.

F. Penalties

1. An MCO in violation of any provision governing the independent review process herein may be subject to a penalty of up to $25,000 per violation.

2. An MCO may be subject to an additional penalty of up to $25,000 if subject to more than 100 independent reviews annually and the percentage of adverse determinations overturned in favor of the provider as a result of an independent review is greater than 25 percent.

G. Independent Review Applicability

1. Independent review shall not apply to any adverse determination:

a. associated with a claim filed with an MCO prior to January 1, 2018, regardless of whether the claim is re-filed after that date;

b. associated with an adverse determination involved in litigation or arbitration;

c. not associated with a Medicaid enrollee.

2. Independent review does not otherwise prohibit or limit any alternative legal or contractual remedy available to a provider to contest the partial or total denial of a claim for payment for healthcare services. Any contractual provision executed between a provider and a MCO which seeks to limit or otherwise impede the appeal process as set forth in this Section shall be null, void, and deemed to be contrary to the public policy of this state.

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, Bureau of Health Services Financing, LR 44:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed

Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821–9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, December 28, 2017 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Rebekah E. Gee MD, MPH

Secretary