

Policy Clarification Related to Provider Recoupment

Managed care organizations (MCOs) are required to process claims for services delivered to retroactively-enrolled members for whom they have received a capitation payment. MCOs are required to process claims from providers upon notification that a member was retroactively or restoratively enrolled as the MCO's member for services provided within the retroactive or restorative enrollment period. MCO's can find information about the retroactive or restorative enrollment on the capitation adjustment file. If the MCO's claims system does not automatically adjudicate the claim for a member who was retroactively or restoratively enrolled, the MCO must process the claims on appeal from providers who document that the MCO's retroactively or restoratively enrolled member was in fee-for-service (FFS) at the time services were rendered. The MCOs must override any prior authorization requirement for services provided without a prior authorization. Standard timely filing and clean claims requirements apply. Claims received from non-network providers should be processed according to out-of-network standards.

If you have questions please contact your health plan management team. Thanks.