



LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON, COMMISSIONER

Post Office Box 94214
Baton Rouge, Louisiana 70804-9214
Phone (800) 259-5300 or
(225) 219-4770 Fax (225) 342-5711
<http://www.lidi.state.la.us>

PHARMACY PROMPT PAYMENT MULTIPLE CLAIM COMPLAINT FORM

**THIS COMPLAINT FORM/SPREADSHEET CAN BE FILED ELECTRONICALLY,
MAILED IN OR ATTACHED TO A C.R.A.F.T COMPLAINT FORM.**

PURPOSE:

This complaint form was designed for pharmacists, who provide services under contract with Health Insurance Issuers/PBMs (Pharmacy Benefits Management Group) for the following types of coverage:

- ◆ Major Medical Insurance
- ◆ Health Maintenance Organization Subscriber Agreements (HMO)

This form is to collect claim samples from pharmacists to document instances where health insurance issuers/PBMs may not be adjudicating claims in a timely manner or not adjudicating claims in accordance with Part VI-F of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950.

FORM COMPLETION INSTRUCTIONS:

General Instructions

- The complaint form is to be used to identify and document a violation listed under Part II of the form and supported by an attached claim. **We cannot accept multiple violations on a single complaint form.** A separate complaint form and claim data sheet **must** be filed for each specific problem to document the violation. The MPPC /03/2007 form and Pharmacy Prompt Payment Spreadsheet may be used for Pharmacy claims filed electronically (E) **only**. This form should be used when filing **six (6) or more** complaints against one health insurance issuer /PBM.
- Pharmacists are to complete all fields that are in **“Green”**, with any comments typed in green. Insurers/PBMs are to complete all fields that are in **“Red”**, with any comments typed in red. Once all fields are completed, the fields in **“Black”** will automatically be computed.
- Determine that each claim being submitted was filed with the health insurance issuer/PBM within the time period for adjudication provided under LA. RS 22:1854. You may be required to provide proof of timely adjudication to dispute a health insurance issuer's/PBM's finding that a claim was not adjudicated in a timely manner. The following documentation will be accepted by the Department in support of a dispute regarding the adjudication of a claim. A copy of the PBM's electronic confirmation transmittal form/sheet to the Pharmacy/Pharmacist that was received on the submittal date of prescription and a copy of the remittance advice that was sent with payment from health insurance issuer/PBM.

- Reconcile all remittance notices with your billing system to assure that the problem is not a posting error.
- Review all correspondence from the health insurance issuer/PBM to verify that additional information was not requested.
- Determine whether “just and reasonable grounds such as would put a reasonable and prudent businessman on his guard” exist on a claim and provide explanations obtained from the health insurance issuer, HMO or PBM. Examples of “just and reasonable grounds” include, but are not limited to:
 - ◆ Investigation of a pre-existing condition or possible contestable contract;
 - ◆ Questionable eligibility of coverage for dependents who are required to be full time students;
 - ◆ Coordination of benefits where there are reasonable grounds to believe other coverage is in effect;
 - ◆ Submission of the explanation of benefits paid by a primary carrier.

Specific Form Instructions:

Part I

Complete this part of the complaint form as indicated.

Part II

Due to the amount of time necessary to conduct an investigation, each complaint must be filed under a category listed below and submitted as a separate complaint form for each type of problem. Each complaint is limited to a **single problem** with a single insurer.

“Claims were not adjudicated timely”- check this box if the health insurance issuer/PBM adjudicated claims after the statutory timeframes and did not pay late payment adjustments or if the adjustment amounts paid were not accurate. If you are not sure if late payment adjustments were calculated accurately, use the spreadsheet to load your data and compare the amount shown with the amount paid by the health insurance issuer.

“Claims rejected for any other reason”- check this box if claims were returned for additional information or incomplete; or if upon resubmission, the claims were denied for timely filing.

“Denial for authorization” – check this box if claims were not adjudicated due to non-authorization when an authorization number was issued or when an authorization was given and then withdrawn after the prescription has been dispensed. **Be sure to list authorization number in comment section of the spreadsheet.**

“Audit of claim after allowed period” – check this box if claims are being audited after the allowed period prescribed by LA. RS 22:1856. Generally, the amount of time a provider has to file a claim is the same amount of time following payment of a claim that the insurer has to give notice of an audit on that claim. In other words, if you are allowed 90 days to file the claim, the insurer has 90 days to give notice of audit after the claim was paid.

“Recoupment of payment without notice” – check this box if claims are not paid or payment was delayed based on recoupment when no notice has been given.

Other (Explain below) – check this box if claims are not adjudicated based on a specific practice that you believe is a violation of insurance law. Please be specific in explaining the violation and the statutory requirement being violated. Disputes on the amount you are being paid under a provider contract must be resolved under the terms of your contract. DOI will investigate any refusal to abide by the arbitration decision or provider hearing ruling after you have completed the insurer’s complaint process.

Completing a data sheet

The Pharmacy Prompt Payment Multiple Claim Spreadsheet performs calculations on claims data based on claims adjudication standards. The correct data must be entered to correctly compute interest due.

Filing a complaint

- Send an e-mail to the following address:
TO: Tangela Byrd at tbyrd@ldi.state.la.us
FROM: The e-mail address used to advise the status of your complaint.
RE: Electronic Provider Complaint Request
Attach one completed complaint form (MPPC 03/2007)
Attach spreadsheet “**Pharmacy Prompt Payment Spreadsheet for Electronic Claims Only”**.
- Within one (1) working day of filing (if complaint is filed through the C.R.A.F.T. system), you should receive an acknowledgement letter/e-mail stating your file number and the name of the compliance examiner who will investigate your complaint.
- An investigation usually takes 15 to 20 working days, depending upon the type of violation and accuracy of information provided to DOI.
- A copy of your complaint will be sent with an electronic cover letter from your examiner requesting explanations from the health insurance company, HMO or PBM.
- Your examiner will review all responses received to assure that all issues have been properly addressed. This may result in further inquiries between the examiner and you, the insurance company, HMO, PBM or other parties.
- Once the investigation is concluded, you will receive a detailed report of the examiner’s findings along with copies of documentation furnished by the insurance company, HMO or PBM.